

HEALTH FORM

**This form must be completed and signed by your Healthcare Provider
and returned to the Allied Health Coordinator with your application and registration form.**

Questions: Contact Diane Bordonaro RN at (860)343-5716 or email dbordonaro@mxcc.comnet.edu

Name _____
Address _____
Date of Birth _____ Phone number _____

On (date) _____ I examined (name) _____
and found this student to be in good health. He/she is free of any communicable disease, can lift 40
pounds and has no known deficits that would interfere with the ability to participate in a clinical setting.

Healthcare Provider

STAMP

Signature: _____

Phone number: _____

Comments: _____

IMMUNIZATIONS

CT State Law requires all students born on or after January 1, 1957 to provide documentation of immunization
against measles, mumps, rubella and varicella (chicken pox) or laboratory evidence demonstrating immunity.
Please provide the information below:

MMR Dose # 1 _____ MMR Dose # 2 _____
Or measles titer _____ and rubella titer _____
results/ date results/ date

Varicella Dose #1 _____ Varicella Dose #2 _____

Or history of chicken pox disease (date) _____

Or Varicella titer _____
results/ date

Hepatitis #1 _____ Hepatitis #2 _____ Hepatitis #3 _____

Or signed waiver

I waive Hepatitis B vaccine at this time:

Student Signature Date

Tuberculosis Testing - must be done within 3 months of 1st class

PPD Date _____ Results _____ mm Date read _____

Nurse's Signature _____

Students with a positive PPD must provide documentation of a chest x-ray and any treatment.

Previous BCG vaccine does not exempt student from tuberculosis testing.