Springfield Technical Community College

One Armory Square
Springfield, MA 01105
(413) 781-7822 • stcc.edu

Non-Health Programs

HEALTH RECORD REQUIREMENT CHECKLIST

This form lists the required health records for all students, pursuant to COVID-19 Vaccine Policy for Students and M.G.L. Chapter 76, Section 15C, and 105 Code of Massachusetts Regulations 220.600..

How to Submit Documentation:

Forms, vaccination records, lab and imaging reports may be submitted to the **Health and Wellness Center** as follows. See next page for more information:

In Person . . . . Building 19, Room 177 Appointment may be required.
Online . . . . Upload pdf files to Dropboox: **https://stccnetportal.stcc.edu/pages/health-wellness-center**
Fax . . . . . . (413) 755-6045
To request health records from another school or provider please complete a Health Record Release Form

Required Health Records Due Prior to 1st day of classes:

☐ **Student Health History Form:** required of all students enrolled at Springfield Technical Community College and must be updated every two years.

Immunization/Immunity Records:

Students taking all on-line courses, with no chance of being on campus, are not required to submit the following immunization records. However, if these students come to campus for any reason, proof of immunization is required.

The following are required of full-time* students less than 30 years of age.

☐ **tetanus, diphtheria and pertussis** (TDaP) – evidence of vaccination within the past 10 years
☐ **measles** – evidence of two vaccinations or immune titer results
☐ **mumps** – evidence of two vaccinations or immune titer results
☐ **rubella** – evidence of two vaccinations or immune titer results
☐ **hepatitis B** – evidence of three vaccinations or immune titer lab report results (surface antiBODY, anti-HBs)
☐ **varicella** (chickenpox) – evidence of two vaccinations, immune titer results or documented history of disease
☐ **meningitis** –Menveo/Menactra (aka MenACWY/MCV4) dose required for those under age 21; or signed meningitis waiver form
☐ **influenza** – recommended for all students during influenza season

***** Full-time is considered 12 or more credits. Students enrolled in certain majors involving a fieldwork component will have additional health record requirements and should not use this form. These additional requirements are based on state law, college policy and fieldwork site requirements.

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Majors requiring additional Health Records: Forms specific for these programs are available at our website: www.stcc.edu/healthservices

- **All programs/HSC classes within the School of Health and Patient Simulation (except: FIRE, MCBS, MEDC)**
- **Workforce Training Programs in Healthcare, including:** Certified Nurse Assistant **(WCNA),** Emergency Medical Technician **(WEMT),** Phlebotomy **(WPHL),** and Dental Radiology **(WDEN)**
- **Behavioral Science Programs (APSY/HSSW)**
- **Early Childhood Education Programs (ECTR, CDA)**

For more information: Health and Wellness Center www.stcc.edu/healthservices
healthservices@stcc.edu | **Phone**: (413) 755-4230 | stcc.edu/chat

- All documentation must include full name, date of birth, date administered or date of exam or date of test.
  - Lab reports must include the date of test, reference range and result.
  -

Understanding your titer results:

- Positive/Reactive means you have immunity.
- Negative/indeterminate/equivocal means you are not immune.
  1. Submit lab report to the Health and Wellness Center
  2. Obtain revaccination and submit documentation

STCC
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Student Health History Form

This form is available online at: https://tinyurl.com/yy4bfomb

Please return form to the Health and Wellness Center (students may fill in information on this form)

MAJOR: _____ **Student ID#** _____

NAME: _____
(last) (first) (middle)

ADDRESS: _____
(street) (city) (state) (zip code)

BIRTH DATE: _____ **TELEPHONE NUMBER:** _____

IN CASE OF EMERGENCY PLEASE CONTACT:
(name) (phone) (relation)

DO YOU HAVE ANY SPECIALIZED NEEDS IN THE EVENT OF AN EMERGENCY OR A BUILDING EVACUATION?

Check at left of each item. If "yes", explain as appropriate

YES	NO	HEALTH HISTORY
☐	☐	1. Hospitalization (date, reason)
☐	☐	2. Operation (date, type)
☐	☐	3. Serious accidents or illnesses
☐	☐	4. Prescription medications? Please list with reason for taking here:
☐	☐	5. Are you currently taking any non-prescription medications, vitamins or diet supplements? If so, please list here:
YES	**NO**	**ALLERGIES to MEDICATIONS and/or ENVIRONMENTAL FACTORS**
☐	☐	6. Allergies to medications? If so, please list:
☐	☐	7. Life threatening reaction to insect bites, food, etc.? If so, please specify:
☐	☐	8. Do you carry an epinephrine injection kit?

YES	NO	HAVE YOU EVER HAD:
☐	☐	9. Chicken Pox
☐	☐	10. Epilepsy (convulsions)
☐	☐	11. Head injury or concussion
☐	☐	12. Fainting or dizziness
☐	☐	13. High blood pressure
☐	☐	14. Any heart problems
☐	☐	15. Chronic or persistent respiratory infection
☐	☐	16. Asthma
☐	☐	17. Gastrointestinal disease
☐	☐	18. Gallbladder disease
☐	☐	19. Thyroid problem
☐	☐	20. Mononucleosis (diagnosed by a clinician)
☐	☐	21. Diabetes
☐	☐	22. Immune Deficiency Problems
☐	☐	23. Kidney disease
☐	☐	24. Cancer
☐	☐	25. Sexually transmitted disease
☐	☐	26. Gynecological problems
☐	☐	27. Are you pregnant or could you be pregnant?
YES	**NO**	**LIFESTYLE**
☐	☐	28. Do you drink alcohol? If so, drinks per week?
☐	☐	29. Current tobacco use: ☐ chew ☐ cigarette ☐ cigar ☐ pipe Quantity per day?
☐	☐	30. Currently Employed? Occupation:
☐	☐	31. Weekly Exercise: ☐Daily ☐3-5 times ☐1-3 times
☐	☐	32. Any recent unexpected weight loss or gain?

Other health concerns:

FAMILY HEALTH HISTORY

YES	NO	CONDITION	RELATIONSHIP	COMMENTS
☐	☐	High Blood Pressure		
☐	☐	Heart Disease		
☐	☐	Diabetes		
☐	☐	Cancer		
☐	☐	Mental/Emotional Illness		
☐	☐	Stomach or Intestinal Illness		
☐	☐	Kidney Disease		
☐	☐	Alcoholism		
☐	☐	Epilepsy/Convulsions		
☐	☐	Tuberculosis		
☐	☐	Stroke/Blood Clotting problems		
☐	☐	Death under age 50		

I ATTEST THAT THIS MEDICAL INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE.

(Student Signature) (Date)