



**GREENFIELD COMMUNITY COLLEGE**  
*Health Services*  
**One College Drive, Greenfield, Massachusetts 01301**  
**TEL: (413) 775-1430 FAX: 775-1434**



**HEALTH REQUIREMENTS**  
**Massage Therapy Students**

Name	_____	_____	_____	_____
	Last	First	Middle	Date of Birth
Address	_____			_____
	Street	Apt.		Student Number or Social Security Number
	_____	_____	_____	
	City	State	Zip Code	
Telephone ( )	_____			
	Area Code			
Semester entering:	Fall 20 ____	Spring 20 ____		
Have you previously attended GCC?	No ____	Yes ____	If yes, when _____	
Previous Name(s)	_____			

**All** Massage Therapy (MTC) students must provide appropriate documentation of immunity as required by the Massachusetts Department of Public Health, Greenfield Community College and clinical sites, **regardless of age or number of credits.** Students must also provide documentation of medical clearance to participate in the MTC program on the Physical Examination form provided.

Students are responsible for providing the Health Service Office with complete health requirement documentation before submitting the MTC Program Application to the Office of Admission.

**Return completed health forms to: Greenfield Community College Health Services Office**, North Module, Main Campus or mail to GCC Health Services, One College Drive, Greenfield MA 01301. Please call the **Health Service Office, (413) 775-1430**, to check that forms have been received and that information is complete. If you have any questions concerning the health requirements for the MTC Program, please call the Health Services Office.

**Prior to application, students are responsible for checking with the Health Services Office for any recent changes in health requirements for this program.**

Office use only:
___ IZ
___ PPD
___ HX
___ PE
___ PC CONSULT
___ ROI

**SECTION I  
IMMUNIZATION INFORMATION**

Student Name \_\_\_\_\_  
Last First Middle

Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
month day year

Has primary DPT series been completed? _____ # DPT doses: _____ date series completed: ____/____/____		
<b>Physician diagnosis of disease is not acceptable</b>	Tetanus-Diphtheria- Pertussis (Tdap)	____/____/____ Tdap
	(if last Tetanus Diphtheria (Td is >2 years old)	____/____/____ Td
	*MMR vaccine #1	____/____/____ *must be on or after date of first birthday and must be after 1/1/68
	** MMR vaccine #2 or Serologic proof of immunity	____/____/____ **must be at least one month after the first dose
	Positive Measles Antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Positive Mumps Antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Positive Rubella antibody (IgG)	____/____/____ → copy of lab report is required, please attach
	Hepatitis B vaccine #1 and Hepatitis B vaccine #2 and Hepatitis B vaccine #3 or Positive Hepatitis B surface antibody	____/____/____ dose #1 ____/____/____ dose #2 ____/____/____ dose #3 ____/____/____ → copy of lab report is required, please attach
	Proof of immunity against Varicella is highly recommended but is optional for Massage Therapy students	
	Positive Varicella antibody	____/____/____ → copy of lab report is required, please attach If the blood test is negative, two doses of vaccine are required to provide immunity
Varicella vaccine #1 and Varicella vaccine #2	____/____/____ ____/____/____ **must be at least 1 month after the first dose	

**Signature of Health Care Provider or Designee is Required:**

Signature \_\_\_\_\_  
Printed Name \_\_\_\_\_  
Address \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_ Date  
\_\_\_\_\_ Telephone  
\_\_\_\_\_ Fax

**SECTION II**  
**HEALTH HISTORY**

(To be filled out by the student)

**COMPLETE AND BRING THIS HISTORY FORM WITH YOU TO YOUR PHYSICAL EXAM APPOINTMENT FOR REVIEW WITH THE EXAMINING HEALTH CARE PROVIDER**

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Please check if you have or have ever had any of the following:

- |  |   |
|--|---|
| <input type="checkbox"/> frequent/severe headaches                 | <input type="checkbox"/> hernia/rupture                               |
| <input type="checkbox"/> seizure disorder/epilepsy                 | <input type="checkbox"/> kidney/bladder problems                      |
| <input type="checkbox"/> dizziness                                 | <input type="checkbox"/> unexplained weight loss/gain                 |
| <input type="checkbox"/> repeated fainting                         | <input type="checkbox"/> swollen glands for longer than 2 weeks       |
| <input type="checkbox"/> problems with vision                      | <input type="checkbox"/> skin disease/disorder                        |
| <input type="checkbox"/> problems with hearing                     | <input type="checkbox"/> back injury or problems                      |
| <input type="checkbox"/> asthma                                    | <input type="checkbox"/> numbness or decreased feeling in hands, feet |
| <input type="checkbox"/> frequent cough                            | <input type="checkbox"/> varicose veins                               |
| <input type="checkbox"/> exposure to tuberculosis/positive TB test | <input type="checkbox"/> diabetes or high blood sugar                 |
| <input type="checkbox"/> shortness of breath/difficulty breathing  | <input type="checkbox"/> anxiety/depression                           |
| <input type="checkbox"/> chest pain with activity                  | <input type="checkbox"/> mental illness                               |
| <input type="checkbox"/> heart disease/condition/murmur            | <input type="checkbox"/> drug/alcohol dependency                      |
| <input type="checkbox"/> high blood pressure                       | <input type="checkbox"/> hospitalization                              |
| <input type="checkbox"/> frequent diarrhea                         | <input type="checkbox"/> surgery                                      |
| <input type="checkbox"/> frequent/severe belly pain                | <input type="checkbox"/> latex allergy _____                          |
| <input type="checkbox"/> cancer                                    | <input type="checkbox"/> other _____                                  |

limited or painful movement or use of:

- |                                 |                                      |                                   |                                   |                                  |
|---------------------------------|--------------------------------------|-----------------------------------|-----------------------------------|----------------------------------|
| <input type="checkbox"/> neck   | <input type="checkbox"/> shoulder(s) | <input type="checkbox"/> elbow(s) | <input type="checkbox"/> wrist(s) | <input type="checkbox"/> hand(s) |
| <input type="checkbox"/> hip(s) | <input type="checkbox"/> knee(s)     | <input type="checkbox"/> ankle(s) | <input type="checkbox"/> feet     | <input type="checkbox"/> back    |

Please explain any items checked: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all medications that you currently take: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all allergies (food, medication, latex, environmental): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have your activities been restricted during the past 5 years?

yes  no  If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Do you have any condition which might require adaptation of your educational/clinical program?

Yes  no  If yes, please describe: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### **SECTION III**

#### **STUDENT STATEMENT**

- ◆ The health history information given is correct to the best of my knowledge.
- ◆ I agree to notify the Health Services Office regarding any significant change in health status.
- ◆ I understand that all health information received by the Health Services Office is confidential and will not be released by the Health Services without my signed consent.
- ◆ I understand that failure to provide complete health requirements by the deadlines will result in the inability to attend classes. I understand that it is my responsibility to provide all the required documentation and to verify the receipt by the Health Services Office of complete documentation.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

### **SECTION IV**

#### **RELEASE of INFORMATION**

I, \_\_\_\_\_ give Greenfield Community College Health  
Please print name  
 Services permission to release information regarding immunizations, immunity to infectious diseases and history of allergies, including latex allergy, to the MTC program coordinator.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

I give Health Services permission to release relevant medical history on a need-to-know basis to the MTC Coordinator if necessary to determine ability to safely participate in the MTC program.

\_\_\_\_\_  
Student's Signature

\_\_\_\_\_  
Date

## SECTION V

### PHYSICAL EXAMINATION (Bring this form to your Physical Exam)

To be completed and signed by a physician, nurse practitioner or physician's assistant

#### A. To the Examining Health Care Provider:

- Successful completion of the **Massage Therapy Certificate Program** requires proficiency in the performance of a variety of skills. Technical standards, meant to clarify minimal standards for essential affective and psychomotor functions, require students to:

1) be ambulatory; 2) be able to lift, support and move through range of motion, a client's head and extremities; 3) possess fine motor skills and tactile ability to distinguish anatomic structures and assess tissue status as massage is applied; 4) possess gross motor skills adequate to apply appropriate pressure, depth and rhythm for massage techniques and to use treatment equipment; 5) have auditory acuity adequate for effective communication; 6) have visual acuity sufficient for client observation and inspection; 7) have emotional stability to exercise sound judgment and intervention; 8) have the emotional maturity to develop appropriate therapeutic relations.

- Please review student history (SECTION II) for completeness and provide any additional history here: (This information is strictly for use by the Student Health Service Office and will not be released without the student's written consent.)

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#### B Physical Examination

Date of Physical Examination      /      /     

Please complete the physical exam form provided, including a summary of active medical problems and recommendations.

Student Name \_\_\_\_\_ D/O/B      /      /      Age     

Height \_\_\_\_\_ Weight \_\_\_\_\_ BP      /      /      Pulse \_\_\_\_\_

Vision: Corrected R      L      Uncorrected R      L     

Hearing: Spoken word      Whispered word      Tuning fork      Audiometry       
(if available)

	normal	abnormal		normal	abnormal
skin/scars			musculoskeletal:		
HEENT			hands		
neck			wrists		
lymph nodes			elbows		
thorax and lungs			shoulders		
heart			spine		
abdomen			hips		
hernia			knees		
peripheral vascular			ankles		
neurological			feet		
mental status			other:		

Please describe and comment on any abnormal findings:

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**C. Summary of Medical/Behavioral Problems and Recommendations:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D. This applicant is capable of full participation in the MTC Program as described by the technical standards in SECTION V, Part A**

yes \_\_\_\_\_ no \_\_\_\_\_

Please describe any accommodations needed to meet the technical standards required for participation in the MTC Program:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Are there any further evaluations which should be performed prior to this applicant's participation?**

Yes \_\_\_\_\_ no \_\_\_\_\_

If yes, please explain and give dates for scheduled evaluations:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Results of additional evaluation(s):

\_\_\_\_ enclosed

\_\_\_\_ to be sent to: Greenfield Community College Health Services  
One College Drive  
Greenfield MA 01301

**E. Signature Required**

\_\_\_\_\_  
Signature

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date

\_\_\_\_ / \_\_\_\_ / \_\_\_\_  
Date of exam

(must be within one year of start date and updated if any significant change in health since exam)

\_\_\_\_\_  
Name of examining MD, NP or PA (please print)

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

FAX: \_\_\_\_\_