

IMMUNIZATIONS

You do not need to have your clinician fill this form if you can upload an official medical record of your immunizations.

Required Vaccines	Dates Received	MA State Requirements
Hepatitis B (may be Hepatitis B OR Hepatitis A/B combined)	Vaccine Name: _____ #1 ____/____/____ #2 ____/____/____ #3 ____/____/____ OR Positive Titer HBsAB Date: ____/____/____ <i>(copy of lab result required)</i>	3 doses; laboratory evidence of immunity acceptable; 2 doses of Heplisav-B given on or after 18 years of age are acceptable.
Meningococcal Quadrivalent 1 dose MenACWY (formerly MCV4) required for all full-time students 21 years of age or younger.	Vaccine Name: _____ Single Dose: ____/____/____ OR Signed Waiver (Link to waiver is below): _____ https://www.mass.gov/doc/information-about-meningococcal-disease-meningococcal-vaccines-vaccination-requirements-and-the-waiver-for-students-at-colleges-and-residential-schools	1 dose; The dose of MenACWY vaccine must have been received on or after the student's 16 th birthday. Students may decline MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form provided in this packet. Meningococcal B vaccine is not required and does not meet this requirement.
MMR (Measles, Mumps, Rubella) OR individual vaccines or titers: • Measles • Mumps • Rubella	#1 ____/____/____ #2 ____/____/____ #1 ____/____/____ #2 ____/____/____ OR Positive Titer Date: ____/____/____ #1 ____/____/____ #2 ____/____/____ OR Positive Titer Date: ____/____/____ #1 ____/____/____ #2 ____/____/____ OR Positive Titer Date: ____/____/____ <i>(copy of lab results required)</i>	2 doses; first dose must be given on or after the 1 st birthday and second dose must be given ≥28 days after first dose; laboratory evidence of immunity acceptable. Birth in the U.S. before 1957 acceptable only for non-health science students.
Tdap (Tetanus, Diphtheria, Pertussis)	Tdap: ____/____/____ *If greater than 10 years ago , must also provide date of recent Td: ____/____/____ or Tdap: ____/____/____	1 dose; and history of a DTaP primary series or age-appropriate catch-up vaccination. Tdap given at ≥7 years may be counted, but a dose at age 11-12 is recommended if Tdap was given earlier as part of a catch-up schedule. Td or Tdap should be given if it has been ≥10 years since Tdap.
Varicella	#1 ____/____/____ #2 ____/____/____ OR Positive Titer Date: ____/____/____ <i>(copy of lab results required)</i> OR History of disease: Yes ____ No ____ Date: ____/____/____	2 doses; first dose must be given on or after the 1 st birthday and second dose must be given ≥28 days after first dose; history of chicken pox as documented by clinician or laboratory evidence of immunity is acceptable. Birth in the U.S. before 1980 acceptable only for non-health science students.
STRONGLY RECOMMENDED & ADDITIONAL IMMUNIZATIONS	Dates Received	Standing Dosing
Influenza	Vaccine Name: _____ Single Dose: ____/____/____	Vaccine for the current flu season
Meningococcal Group B MenB-4C (Bexsero) OR MenB-Fhbp (Trumenba)	Vaccine Name: _____ #1 ____/____/____ #2 ____/____/____ #1 ____/____/____ #2 ____/____/____ #3 ____/____/____	Bexsero: 2 doses at least one month apart Trumenba: 3 doses at 0, 3 and 6 month intervals
Human Papillomavirus (HPV)	Vaccine Name: _____ #1 ____/____/____ #2 ____/____/____ #3 ____/____/____	3 doses at 0, 3 and 6 month intervals
Hepatitis A OR Hepatitis A & B Combined	Vaccine Name: _____ #1 ____/____/____ #2 ____/____/____ #1 ____/____/____ #2 ____/____/____ #3 ____/____/____	Hepatitis A: 2 doses at least 6 months apart Hepatitis A & B Combined: 3 doses given at 0, 3 and 6 month intervals.
COVID-19 Vaccines:	Vaccine Name: _____ Date: ____/____/____ Vaccine Name: _____ Date: ____/____/____ Vaccine Name: _____ Date: ____/____/____ Vaccine Name: _____ Date: ____/____/____	COVID-19 vaccines per CDC recommendations.

HEALTHCARE PROVIDER'S SIGNATURE:

Healthcare Provider's Name (Please Print): _____ Signature: _____ Date: ____/____/____

Address: (Including City and State): _____ Phone #: () _____