Immunization Record-Page 1

Massachusetts State Law requires proof of immunity **prior to matriculation**. Please use this form to record immunization dates **or send a copy of your record from your physician's office.**

NAME_____

Last **First** **Middle** **Date of Birth**

REQUIRED IMMUNIZATIONS
Massachusetts State Law requires all immunizations on Page 1

A

Tetanus, Diphtheria, Pertussis-Tdap **Date of Immunization Required**		**Tetanus, Diphtheria-Td** **Required if more than 10 years since Tdap**
Tdap: _____/_____/_____ Mo Day Year	**AND**	**Td**: _____/_____/_____ Mo Day Year

B

Measles, Mumps, Rubella (MMR)-Two doses Required
Dates of Immunizations or Proof of Immunity Required

MMR #1: _____/_____/_____(After 12 months of age) Mo Day Year

MMR #2: _____/_____/_____ (At least 1 month after dose 1) Mo Day Year

OR

◇ **Exempt** (born before 1957)

◇ **Positive Lab Titers** (Lab reports **MUST** be included)

C

Hepatitis B or Hepatitis A/B
Dates of Immunizations or Proof of Immunity Required

Engerix-B or Recombivax HB	**Twinrix** (After 18 years of age)	**Heplisav-B** (After 18 years of age)
Dose #1: _____/_____/_____ *Any Elected Date*	**Dose #1:** _____/_____/_____ *Any Elected Date*	**Dose #1:** _____/_____/_____ *Any Elected Date*
Dose #2: _____/_____/_____ *At least 28 days after Dose #1*	**Dose #2:** _____/_____/_____ *At least 28 days after Dose #1*	**Dose #2:** _____/_____/_____ *At least 28 days after Dose #1*
Dose #3: _____/_____/_____ *At least 4 months after 1st Dose and 8 weeks after 2nd Dose*	**Dose #3:** _____/_____/_____ *At least 6 months after 1st Dose and 5 months after 2nd Dose*	**OR** ◇ **Positive Lab Titers** (Lab reports required)

D

Meningitis Immunization/Waiver
*Must have been administered within the past 5 years on/after 16th birthday
Date of Immunization or Signed Waiver Required

◇ **MCV4 (Menactra or Menveo)**: _____/_____/_____ Mo Day Year

◇ **MPSV4 (Menomune)**: _____/_____/_____ Mo Day Year

◇ **Menquadfi**: _____/_____/_____ Mo Day Year

OR

◇ **Waiver Signed**

E

Varicella -Two doses Required
Date of Immunizations, Positive History of Chicken Pox, or Proof of Immunity Required

◇ **Positive History of Disease** _____/_____/_____ **(MUST include date of disease)** Mo Day Year

◇ **Positive Lab Titers** (Lab reports required)

◇ **Exempt** (born before 1980)

OR

Varicella #1: _____/_____/_____(After 12 months of age) Mo Day Year

Varicella #2: _____/_____/_____ (At least 1 month after dose 1) Mo Day Year

Health care provider signature or stamp-REQUIRED

SIGNATURE _____

Immunization Record-Page 2

Please use this form to record immunization dates. Page 2 list all immunizations that are **RECOMMENDED** vaccinations for students.

NAME_____

Last **First** **Middle** **Date of Birth**

Covid-19 **STRONGLY RECOMMENDED**

Covid-19 Vaccine Dose #1: _____/_____/_____ **Dose #2:** _____/_____/_____ **Dose #3:** _____/_____/_____
Mo Day Year **Mo Day Year** **Mo Day Year**

Vaccine Received ◇ Pfizer ◇ Moderna ◇ Johnson & Johnson ◇ Other _____

Meningitis B **STRONGLY RECOMMENDED**

Trumenba (3 Doses) **Dose #1:** ____/____/____ **Dose #2:** ____/____/____ **Dose #3:** ____/____/____

Bexsero (2 Doses) **Dose#1:** ____/____/____ **Dose #2:** ____/____/____

Influenza **RECOMMENDED**

Influenza: _____/_____/_____
Mo Day Year

Human Papilloma Virus Recombinant Vaccine (HPV2, HPV4, HPV9) **RECOMMENDED**

HPV #1: _____/_____/_____ **HPV #2:** _____/_____/_____ **HPV #3:** _____/_____/_____
Mo Day Year Mo Day Year Mo Day Year

Hepatitis A **RECOMMENDED**

Hepatitis A #1: _____/_____/_____ **Hepatitis A #2:** _____/_____/_____
Mo Day Year Mo Day Year

Pneumococcal Polysaccharide Vaccine **RECOMMENDED** For High Risk Individuals

Date of Dose: _____/_____/_____
Mo Day Year

Health care provider signature or stamp-REQUIRED

SIGNATURE _____