Certificate of Immunization

Upload to the Student Heath Portal (dean.studenthealthportal.com)

Student Name_____ Date of Birth_____
Last First MI

Massachusetts State Law requires the following immunizations of ALL students. Exact dates are required for immunizations or serological test results. **Please include copies of laboratory reports, if titers done**.

1. **Hepatitis B vaccine: #1**____/____/____ **#2**____/____/____ **#3**____/____/____
Month/Day/Year Month/Day/Year Month/Day/Year

OR positive titer:____/____/____ (anti-HBs/HBsAb) ***attach/upload copy of laboratory report***
Month/Day/Year

2. **MMR** (measles, mumps, rubella) **2 doses required**
#1: ____/____/____ (*on or after 1st birthday*) **#2:** ____/____/____ (*at least 1 month after 1st dose*)
Month/Day/Year Month/Day/Year

OR **Measles** (Rubeola) positive titer: ____/____/____ **Result:** _____
Month/Day/Year ***attach/upload copy of laboratory report***

Mumps positive titer: ____/____/____ **Result:** _____
Month/Day/Year ***attach/upload copy of laboratory report***

Rubella positive titer: ____/____/____ **Result:** _____
Month/Day/Year ***attach/upload copy of laboratory report***

3. **Tdap** ____/____/____ **Td (within last 5 years)** ____/____/____
Month/Day/Year Month/Day/Year

4. **Meningococcal Vaccine** (Groups A, C, Y and W-135)**:** ____/____/____ ☐ Menactra
on or after16th birthday Month/Day/Year ☐ MenACWY

OR upload a copy of a signed **DPH Waiver Form**

5. **Varicella Vaccine 2 doses required** **#1** ____/____/____ **#2**____/____/____
Month/Day/Year Month/Day/Year

History of chicken Pox Date: ____/____/____ **Positive Titer**: ____/____/____
Month/Day/Year Month/Day/Year

6. **Tuberculosis Screening: Mantoux Skin Test** (PPD) **is required of all high-risk and international students, regardless of prior BCG inoculation. Please refer to TB Risk Questionnaire form and have student complete the 3 questions. If applicable, complete the following:**

Student is low risk for TB: ☐

PPD (within last 12 months): T**est date**: _____/_____/_____ **Result in mm:** _____

Chest X-ray date (in last 6 months, if positive PPD): ____/____/____ **Result**: _____

IF POSITIVE PPD, treatment with**:** _____ **Dates**: From_____ To_____

Health Care Provider: Office Phone and Fax#:_____/_____

_____
Provider's Signature Date