Certificate of Immunization

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 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

If no record of MMR vaccine, please indicate laboratory evidence of immunity:

Measles (rubeola) positive titer: ____/____/____ **Result:** _____
Month/Day/Year *attach laboratory report*

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

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

3. **Tdap (within last 10 years)** ____/____/____ **OR** **Td (within last 5 years)** ____/____/____
Month/Day/Year Month/Day/Year

4. **Meningococcal Vaccine** (Groups A, C, Y and W-135)**:** ____/____/____ ☐ Menactra
(within last 5 years) Month/Day/Year ☐ Menomune

OR signed **DPH Waiver Form** ____/____/____
Month/Day/Year

5. **Varicella Vaccine** **#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#:_____/_____

_____
Signature Date

Revised 07/13