HAMPSHIRE COLLEGE HEALTH & COUNSELING SERVICES

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IMMUNIZATION FORM - TO BE FILLED OUT BY HEALTHCARE PROVIDER

THIS FORM IS REQUIRED · DUE JULY 1 FOR FALL AND JANUARY 15 FOR SPRING

This form should be completed by a healthcare provider who is not a family member. Submit by July 1 for the fall semester and January 15 for the spring semester

Legal Name: ______________________________ Date of Birth: _____/______/___________
Last First Middle Initial month day year

Chosen Name(if different):____

REQUIRED IMMUNIZATIONS (to be completed by a healthcare provider)

The following immunizations are required by Massachusetts Law. All dates must include month/day/year. If documentation of immunization is not available or if a blood test indicates that you are NOT immune, you must be re-immunized.

TETANUS-DIPTHERIA-PERTUSSIS
One dose of Tdap is required within the last 10 years.

Tdap Date: _________/ ________ / _________
mo. day year

M.M.R. (Measles, Mumps, Rubella) (two doses required, at least one month apart, after 12 months of age)

Dose 1: ______ / _______ / _______ Dose 2: _______ / _______ / _____
mo. day year mo. day year

OR Positive titer date:_____/_____/_________ (lab report must be included)
mo. day year

MENINGOCOCCAL - Serogroup ACWY
Quadrivalent MCV4(Menactra or Menveo)

____/_____/_________
mo. day year

One dose at 16 or older for all incoming students age 21 or younger; second dose highly recommended

or

Waiver; available on health services website under student forms

HEPATITIS B (three doses required)

Dose 1: ______ / _______ / _________
mo/ day year

Dose 2: ______ / _______ / _________
mo. day year
(MUST BE AT LEAST ONE MONTH AFTER #1)

Dose 3: ______ / _______ / _________
mo. day year
(MUST BE AT LEAST TWO MONTHS AFTER #2 AND FOUR MONTHS AFTER #1)

OR Positive HbsAb titer
(lab report must be included) ______/______/_________
mo. day year

VARICELLA (2 doses required for college first year students unless they have a reliable history of chickenpox).
A reliable history includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee; or 2) laboratory proof of immunity. Birth before 1980 in U.S. is acceptable for college students, except health science students. (*two doses required, at least 1 month apart)*

Dose 1: ______ / ______ / _________ Dose 2: _________ / _________ / _________
mo. day year mo. day year

OR Lab test proving immunity (attach lab reports) Immune-Titer value __________ Date: ________ / _______ / ________
mo. day year

OR History of Disease, Date: ________ / ______ / ________
mo. day year

STRONGLY RECOMMENDED IMMUNIZATIONS (to be completed by a healthcare provider)

MENINGITIS B

TYPE: _____________

Dates given: ________

____

____

HEPATITIS A (two doses at least 6 months apart)

Dose 1: ______ / ______ / ______ Dose 2: ______ / ______ / ______
mo. day year mo. day year

PNEUMOCOCCAL VACCINE

The CDC recommends vaccination for adults who have health conditions including asthma, diabetes and other chronic problems; those with compromised immune systems and smokers.

Pneumovax: ________/ ________ / ________
mo. day year

HUMAN PAPILLOMA VIRUS (HPV)

Vaccine (at 0,2, and 6 month intervals)

☐ **Gardasil** ☐ Other

Dose 1: _______ /_______ /_________

Dose 2: _______ /_______ /_________

Dose 3: ________ /_______ /_________

HEALTHCARE PROVIDER SIGNATURE REQUIRED

NAME (PRINT): ____ DATE: ____________________

ADDRESS: ____

PHONE: ____________________ FAX: _________________________ SIGNATURE: ________________________________

IMPORTANT NOTICE: FAILURE TO COMPLY WITH THE MASSACHUSETTS IMMUNIZATION LAW WILL RESULT IN A HOLD BEING PLACED ON YOUR REGISTRATION