HAMPSHIRE COLLEGE HEALTH & COUNSELING SERVICES

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IMMUNIZATION FORM - TO BE FILLED OUT BY HEALTHCARE PROVIDER

THIS FORM IS REQUIRED . DUE JULY 15 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 15 for the fall semester and January 15 for the spring semester Legal Name: _ Middle Initial Date of Birth: / / year 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) M.M.R. (Measles, Mumps, Rubella) (two doses required, at least one month apart, after 12 months of age) Dose 1: ____ / __day / __year _ Dose 2: ____ / __day / __year INFLUENZA- (one dose after August 1, 2020) **HEPATITIS B** (three doses required) MENINGOCOCCAL - Serogroup ACWY Quadrivalent MCV4(Menactra or Menveo) Dose 1: ______ / _day ___ / _year Dose 2: _____ / _day ___ / _year (MUST BE AT LEAST ONE MONTH AFTER #1) mo. dav vear One dose at 16 or older for all incoming students age 21 or younger; second dose Dose 3: ____ / __ day __ / __ year __ (must be at least two months after #2 and four months after #1) highly recommended OR Positive HbsAb titer (lab report must be included) mo. / day / year Waiver; available on health services website under student forms 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) STRONGLY RECOMMENDED IMMUNIZATIONS (to be completed by a healthcare provider)

MENINGITIS B	HEPATITIS A (two doses at least 6 months apart)	HUMAN PAP	ILLOMA VIRUS (HPV)
ТҮРЕ:	Dose 1:/	Vaccine (at 0,2,	and 6 month intervals)
	PNEUMOCOCCAL VACCINE	☐ Gardasil	□ Other
Dates given:	The CDC recommends vaccination for adults who have health	Dose 1:	/ /
	conditions including asthma, diabetes and other chronic problems; those with compromised immune systems and smokers.	Dose 2:	_ / /
	Pneumovax:mo/day/year	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