HAMPSHIRE COLLEGE HEALTH & COUNSELING SERVICES
893 West Street, Amherst, MA 01002
PH (413) 559.5458 FX (413) 559.5583 healthservices@hampshire.edu

IMMUNIZATION FORM

THIS FORM IS REQUIRED · STUDENT COMPLETES · 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

Name: _____ Date of Birth _____
Last First Middle Initial

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.

Tdap Date: _____/ _____/ _____

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

Dose 1: _____ / _____ / _____ Dose 2: _____ / _____ / _____

OR Laboratory Proof of Immunity (Attach copy of lab reports)

MENINGOCOCCAL

Date Administered: _____ / _____ / _____

☐ Menactra (MCV4)
☐ Menomune (MPSV4) (within 5 years)

WAIVER: If not immunized, please complete the Waiver form available on website:

HEPATITIS B (three doses required)

Dose 1: _____ / _____ / _____
Dose 2: _____ / _____ / _____
(MUST BE AT LEAST ONE MONTH AFTER #1)
Dose 3: _____ / _____ / _____
(MUST BE AT LEAST TWO MONTHS AFTER #2 AND FOUR MONTHS AFTER #1)

OR Laboratory Proof of Immunity (Attach copy of lab reports)

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.

Dose 1: _____ / _____ / _____ Dose 2: _____ / _____ / _____

OR Lab test proving immunity (attach lab reports) Immune-Titer value _____ Date: _____ / _____ / _____

OR History of Disease, Date: _____ / _____ / _____

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

HEPATITIS A (two doses at least 6 months apart)

Dose 1: _____ / _____ / _____ Dose 2: _____ / _____ / _____

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: _____/ _____/ _____

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

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TUBERCULOSIS SCREENING

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

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

Name: _____ Date of Birth _____
Last First Middle Initial

SECTION I: REQUIRED TUBERCULOSIS (TB) RISK QUESTIONNAIRE

REQUIRED

1. Have you ever been treated for active TB? ☐ Yes ☐ No
   If yes, give dates of treatment From: ____/____/____ to ____/____/____
2. Have you ever had a positive TB skin or blood test? ☐ Yes ☐ No
   If yes, when? From: ____/____/____ to ____/____/____
3. Have you ever been treated for latent TB? ☐ Yes ☐ No
   If yes, give dates of treatment From: ____/____/____ to ____/____/____

REQUIRED

4. Were you born in one of the countries listed on page 3? ☐ Yes ☐ No
   If yes, please specify _____
   If yes, when did you come to the U.S.? ____/____/____
5. Have you traveled for more than a month in a country with a high rate of TB, as listed on page 3? ☐ Yes ☐ No
6. To the best of your knowledge, have you ever had close contact with anyone sick with TB? ☐ Yes ☐ No
7. Have you even been vaccinated with BCG? ☐ Yes ☐ No

IF YOU ANSWERED "NO" TO ALL OF THE ABOVE, SKIP SECTIONS II and III

SECTION II: MEDICAL EVALUATION OF COLLEGE AND UNIVERSITY STUDENTS FOR LATENT TUBERCULOSIS INFECTION (ALL TUBERCULIN SKIN TESTING MUST BE DONE WITHIN THE UNITED STATES OR CANADA.)

REQUIRED IF RISKS IDENTIFIED

A. TUBERCULIN SKIN TEST* (within 6 months prior to entrance) DATE ADMINISTERED _____

Result (48-72 hours) _____ **mm of induration in horizontal diameter.**
(If no induration, mark "0.")

**Note: Use 5 TU Mantoux test (Intermediate PPD) only; result of multiple puncture tests, such as Tine, Heaf, or Mono-vacc, not accepted. If unavailable please defer testing until you arrive at Hampshire College.*

Risk-based interpretation (see reverse side) ☐ Negative ☐ Positive **If positive, please complete Section III**

B. Interferon Gamma Release Assay (IGRA)

Date Obtained:_____ /_____/ _____ (specify method) ☐ QFT-G ☐ QFT-GIT other _____

Result ☐ Negative ☐ Positive ☐ Intermediate

SECTION III CHEST X-RAY AND TREATMENT

REQUIRED IF PPD OR IGRA IS POSITIVE

Chest x-ray required** (within 12 months if PPD or IGRA is positive)

☐ Negative ☐ Positive Date _____

Treatment (required for active tuberculosis, recommended for latent tuberculosis infections)

☐ No ☐ Yes _____
DRUG, DOSE, FREQUENCY, AND DATES

***If PPD or IGRA has been positive in the past but student was not treated for active or latent TB, a chest x-ray is required within 12 months prior to enrollment.*

HEALTHCARE PROVIDER SIGNATURE REQUIRED

REQUIRED

NAME (PRINT): _____ DATE: _____

ADDRESS: _____

PHONE: _____ SIGNATURE: _____

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COUNTRIES WITH HIGH RATES OF TUBERCULOSIS (TB)*

*World Health Organization Global Tuberculosis Database 2009

Afghanistan
Algeria
Angola
Anguilla
Armenia
Azerbaijan
Bahrain
Bangladesh
Belarus
Belize
Benin
Bhutan
Bolivia
Bosnia & Herzegovina
Botswana
Brazil
British Virgin Islands
Brunei Darussalam
Bulgaria
Burkina Faso
Burundi
Cambodia
Cameroon
Cape Verde
Central African Republic
Chad
China
China, Hong Kong SAR
China, Macao SAR Colombia *
Comoros
Congo
Cook Islands
Côte d'Ivoire
Djibouti
Dominican Republic DPR
Korea
DR Congo
Ecuador
El Salvador
Equatorial Guinea
Eritrea
Ethiopia
Gabon
Gambia
Georgia
Ghana
Guam
Guatemala
Guinea
Guinea-Bissau
Guyana
Haiti
Honduras
India
Indonesia
Iraq
Kazakhstan
Kenya
Kiribati
Kyrgyzstan
Lao PDR
Lesotho
Liberia
Libyan Arab Jamahiriya
Lithuania
Madagascar
Malawi
Malaysia
Mali
Marshall Islands
Mauritania
Mauritius
Mexico *
Micronesia
Mongolia
Montserrat
Morocco
Mozambique
Myanmar
Namibia
Nauru
Nepal
Nicaragua
Niger
Nigeria
Northern Mariana Island
Pakistan
Palau
Panama
Papua New Guinea
Paraguay
Peru
Philippines
Poland *
Portugal *
Qatar
Rep. Korea
Republic of Moldova
Romania
Russian Federation
Rwanda
Sao Tome & Principe Senegal
Seychelles
Sierra Leone
Solomon Islands
Somalia
South Africa
Sri Lanka
Sudan
Suriname
Swaziland
Taiwan
Tajikistan
Thailand
Timor-Leste
Togo
Turkmenistan
Tuvalu
Uganda
Ukraine
UR Tanzania
Uzbekistan
Vanuatu
Vietnam
Yemen
Zambia
Zimbabwe

RISK-BASED INTERPRETATION OF TUBERCULIN SKIN TEST

RISK FACTOR	POSITIVE RESULT
Close contact with a case of tuberculosis	5 mm or more
Born in a country that has a high rate of tuberculosis Traveled or lived for one month or more in a country that has a high rate of tuberculosis	10 mm or more 10 mm or more
None (test not recommended)	15 mm or more