



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: Last First Middle Initial Date of Birth: 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.

Form containing immunization requirements for TETANUS-DIPHTHERIA-PERTUSSIS, INFLUENZA, MENINGOCOCCAL, HEPATITIS B, and VARICELLA. Includes fields for dates, doses, and lab reports.

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

Form containing immunization requirements for MENINGITIS B, HEPATITIS A, PNEUMOCOCCAL VACCINE, and HUMAN PAPILLOMA VIRUS (HPV). Includes fields for dates, doses, and vaccine types.

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