

SEND TO: Attn: **Student Records**  
 Ourania Behrakis Student Center  
 Northern Essex Community College  
 100 Elliott Street, Haverhill, MA 01830  
 978-556-3700 / fax 978-556-3729



FOR OFFICE USE ONLY:  
 RCVD: \_\_\_\_\_  
 STU. ID: \_\_\_\_\_  
 PROGRAM CODE: \_\_\_\_\_

# Immunization Requirement Form

**A completed form must be received within 30 days after registering for classes**

Massachusetts Department of Public Health Immunization Requirement for College Entry State Law 105 CMR 220.600: M.G.L. c.76 § 15C states that students must have 1 injection of Tetanus/Diphtheria within 10 years, 2 injections of Measles, 1 injection of Mumps, 1 injection of Rubella, and 3 injections of Hepatitis B vaccine. College immunization requirements apply to:

1. All full-time undergraduate and graduate students (full-time = enrolled in 12 or more credits)
2. All full-time and part-time health science students, and other students enrolled in a program which requires immunization compliance in order to participate in a practicum setting
3. All full-time and part-time students on a student or other visa, including foreign students attending or visiting classes as part of a formal academic visitation exchange program

## THIS SECTION MUST BE COMPLETED BY STUDENT

**HEALTH RECORD RETENTION POLICY:** All students are encouraged to establish a file for their medical records. Make a copy of this form prior to submitting. The college charges a fee for students to receive a copy of immunization records. Immunization records are retained by the college for five (5) years only.

LAST NAME: \_\_\_\_\_ FIRST: \_\_\_\_\_ MI: \_\_\_\_\_ MAIDEN/OTHER NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ DATE OF BIRTH:     /     /     LAST FOUR DIGITS OF SOCIAL SECURITY NUMBER: \_\_\_\_\_

PROGRAM OF STUDY: \_\_\_\_\_ SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

Signing this form authorizes the release of immunization records/information to Northern Essex Community College.

## THIS SECTION MUST BE COMPLETED BY MEDICAL PROVIDER

**MEDICAL PROVIDERS MUST USE THIS FORM ONLY.**

**HEALTH RECORD SUBMISSION POLICY:**

1. New Immunizations must be recorded on this form only and a medical professional's signature is required.
2. Copies of old immunization records and/or lab reports for positive immunization titers must be attached to this form.
3. All records, old or new, must be legible to be accepted. Titer lab reports must clearly indicate immunity to be accepted. Students will be asked to re-submit illegible documents, which may require a medical professional's signature.

### Td: Tetanus/Diphtheria

1 Injection within 10 years

Td     /     /      
 Injection Date

### MMR: Measles, Mumps, Rubella

Must be completed in 1 of 3 ways:

2 Injections of MMR

Injections **MUST** be given on/after 1st birthday and after 1968.

MMR1     /     /     MMR2     /     /      
 1st Injection Date (At least 1 month after 1st dose)  
 2nd Injection Date

OR: 2 Measles, 1 Mumps, 1 Rubella

**MUST** be given on/after 1st birthday, Measles given after 1968.

Measles1     /     /     Mumps     /     /      
 1st Injection Date Injection Date

Measles2     /     /     Rubella     /     /      
 2nd Injection Date Injection Date

OR: MMR Positive Immune Titers

**MUST** also attach a laboratory-confirmed result of serological immunity. Lab reports must **clearly** indicate immunity.

Measles/Rubeola Immune Titer     /     /      
 (MUST attach lab report confirming immunity) Drawn Date

Mumps Immune Titer     /     /      
 (MUST attach lab report confirming immunity) Drawn Date

Rubella Immune Titer     /     /      
 (MUST attach lab report confirming immunity) Drawn Date

### HBV: Hepatitis B

Must be completed in 1 of 3 ways:

3 Injections of HBV

HBV1     /     /      
 1st Injection Date

HBV2     /     /      
 (recommended 1 month after 1st dose)  
 2nd Injection Date

HBV3     /     /      
 (Recommended 5 months after 2nd dose)  
 3rd Injection Date

OR: 2 10mcg Merck's Recombivax HB®

**MUST** be administered between the ages of 11-15.

2-dose formulation: 1     /     /      
 1st Injection Date

2-dose formulation: 2     /     /      
 (MUST be administered within 4 months after 1st dose)  
 2nd Injection Date

OR: HBV Positive Immune Titer

**MUST** also attach a laboratory-confirmed result of serological immunity. Report must **clearly** indicate immunity.

HBV Immune Titer     /     /      
 (MUST attach lab report confirming immunity) Drawn Date

FACILITY STAMP HERE:

PHYSICIAN'S/NURSE'S SIGNATURE: \_\_\_\_\_ PRINT LAST NAME: \_\_\_\_\_

PHONE: \_\_\_\_\_ ADDRESS: \_\_\_\_\_ DATE: \_\_\_\_\_