

SEND TO: Attn: Student Records
Ourania Behrakis Student Center
Northern Essex Community College
100 Elliott Street, Haverhill, MA 01830
978-556-3700 / fax 978-556-3160



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

(as mandated by Massachusetts Department of Public Health Immunization Requirements for College Entry Regulation 105CMR 220.600 And M.G.L. c. 76 §§15 and 15C)
<http://www.mass.gov/Eeohhs2/docs/dph/regs/105cmr220.pdf> (see section 220.600)

THIS SECTION SHOULD 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: ____m ____d ____y 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.

REQUIRED VACCINES Students must have proof of 1 injection of Tetanus/Diphtheria or Tdap within 10 years, 2 injections of Measles, 1 injection of Mumps, 1 injection of Rubella, and 3 injections of Hepatitis B vaccine. Proof of immunity by laboratory titer is acceptable for MMR and Hepatitis B.

THESE SECTIONS FOR COMPLETION BY MEDICAL PROVIDER

Tetanus/Diphtheria (Td)

Tetanus/Diphtheria/Pertussis (Tdap)

OR

Month Day Year

Month Day Year

Dose must be within 10 years

MMR (Measles/Mumps/Rubella)

OR

Measles1

(separate doses)

Measles2

Dose 1

Dose 2

Must be given after First Birthday and after 1968

Mumps1

Rubella1

Month Day Year

Month Day Year

(Must be one month after dose 1)

Month Day Year

Month Day Year

OR

Lab Titers (results must be attached)

Measles Titer _____

Month Day Year

Mumps Titer _____

Month Day Year

Rubella Titer _____

Month Day Year

* Laboratory Titer Results must be attached

Hepatitis B (HBV 3 dose series)

OR

Lab titer (results must be attached)

Dose 1

Dose 2

Dose 3

Month Day Year

Month Day Year

(Must be one month
after dose 1)

Month Day Year

(Recommended 5
months after dose 2)

HBV Titer _____

Month Day Year

* Laboratory Titer Results must be attached

RECOMMENDED, but not required until 2010

Varicella (Chicken Pox 2 dose series)

OR

Lab titer (results must be attached)

Dose 1

Dose 2

Month Day Year

Month Day Year

(Must be one month after dose 1)

Varicella Titer _____

Month Day Year

* Laboratory Titer Results must be attached

PHYSICIAN'S/NURSE'S SIGNATURE: _____ PRINT LAST NAME: _____

PHONE: _____ ADDRESS: _____ DATE: _____

* Physician's signature is required, unless immunization records are attached. Records need to be clearly identified and legible.

* Results of laboratory titers, if done, need to be attached to this form.

Form Revised 6/12/09