

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 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 within 5 years or Tdap, 2 injections of Measles, 1 injection of Mumps, 1 injection of Rubella, 3 injections of Hepatitis B, and 2 injections of Varicella. Proof of immunity by laboratory titer is acceptable for MMR, Hepatitis B, and Varicella.

THESE SECTIONS COMPLETED BY MEDICAL PROVIDER

Varicella (Chicken Pox 2 dose series)		OR	OR	Laboratory Titers *Results must be attached
Dose 1	Dose 2	History of Disease+		
		+Health Professions Students not eligible to submit this form of proof		
_____	_____	_____		Varicella Titer _____
Month Day Year	Month Day Year	Month Day Year		Month Day Year
(Must be at least one month after dose 1)				

MMR (Measles/Mumps/Rubella)		OR	Measles1 _____	Separate Doses
Dose 1	Dose 2		Measles2 _____	
			Mumps1 _____	
			Rubella1 _____	
_____	_____			
Month Day Year	Month Day Year			
	(Must be at least one month after dose 1)			
		OR	Laboratory Titers *Results must be attached	
Measles Titer _____	Mumps Titer _____		Rubella Titer _____	
Month Day Year	Month Day Year		Month Day Year	

Hepatitis B (HBV 3 dose series)			OR	Laboratory Titers *Results must be attached
Dose 1	Dose 2	Dose 3		
_____	_____	_____		HBV Titer _____
Month Day Year	Month Day Year	Month Day Year		Month Day Year
	(Must be at least one month after dose 1)	(Recommended 5 months after dose 2)		

Tetanus/Diphtheria (Td)	OR	Tetanus/Diphtheria/Pertussis (Tdap)
+Health Professions Students not eligible to submit this form of proof		
_____		_____
Month Day Year		Month Day Year
Dose must be within 5 years		

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. Revised 10/1/11