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

Northern Essex Community College

STUDENT ID: _____

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 220.60(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 2 injections of Varicella, 2 injections of MMR, 3 injections of Hepatitis B, and 1 injection of Tdap. 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** ***Report 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) **All doses must be given after First Birthday and after 1968**

Dose 1 Dose 2

_____ _____

Month Day Year Month Day Year

(Must be at least one month after dose 1)

OR **Laboratory Titers** ***Report 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** ***Report 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/Pertussis (Tdap)

_____

Month Day Year

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 2/15/13***