

# Immunization Requirement Form

ENTER YOUR STUDENT ID: \_\_\_\_\_

SEND COMPLETED FORM TO: Attn: Student Records, Northern Essex Community College, 100 Elliott Street, Haverhill, MA 01830 (fax 978-556-3729)  
**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 M.G.L. c. 76 §§15 and 15C) Massachusetts General Laws Part I Title XII Chapter 76

## THIS SECTION TO BE COMPLETED BY THE 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. Immunization records are retained by the college for five (5) years only.

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Maiden/Other Name: \_\_\_\_\_

Phone: \_\_\_\_\_ Last Four Digits of Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ month/day/year

Program of Study: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ month/day/year

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

**REQUIRED VACCINES:** Students must have proof of 3 injections of Hepatitis B, 1 injection of MenACWY (21 years of age and younger) administered after 16<sup>th</sup> birthday, 2 injections of MMR, 1 injection of Seasonal Influenza, 1 injection of Tdap and 2 injections of Varicella. Proof of immunity by laboratory titer is acceptable for MMR, Hepatitis B and Varicella.

## THIS SECTION TO BE COMPLETED BY THE MEDICAL PROVIDER

### Hepatitis B (HBV 3 dose series)

Dose 1 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year

Dose 2 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year (must be at least one month after dose 1)

Dose 3 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year (recommended 5 months after dose 2)

OR

**Laboratory Titers** (Report must be attached):

**HBV Surface Antibody Titer** \_\_\_/\_\_\_/\_\_\_ month/day/year

**Meningococcal – MenACWY** (21 years of age and younger/immunization administered after 16<sup>th</sup> birthday) \_\_\_/\_\_\_/\_\_\_ month/day/year

### MMR Measles/Mumps/Rubella (All doses must be given after first birthday and after 1968)

Dose 1 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year

Dose 2 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year (must be at least one month after dose 1)

OR

**Laboratory Titers** (Report must be attached).

**Measles Titer:** \_\_\_/\_\_\_/\_\_\_ month/day/year

**Mumps Titer:** \_\_\_/\_\_\_/\_\_\_ month/day/year

**Rubella Titer** \_\_\_/\_\_\_/\_\_\_ month/day/year

**Seasonal Influenza:** \_\_\_/\_\_\_/\_\_\_ month/day/year

**Tetanus/Diphtheria/Pertussis (Tdap):** \_\_\_/\_\_\_/\_\_\_ month/day/year

### Varicella (Chicken Pox – 2 dose series):

Dose 1 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year

Dose 2 Date: \_\_\_/\_\_\_/\_\_\_ month/day/year (must be at least one month after dose 1)

OR

**History of Disease** (Health Professions students not eligible to submit this form of proof): \_\_\_/\_\_\_/\_\_\_ month/day/year

OR

**Laboratory Titers** (Report must be attached).

**Varicella Titer:** \_\_\_/\_\_\_/\_\_\_ month/day/year

Physician/Nurse Signature: \_\_\_\_\_

Print Last Name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_ month/day/year