Northern Essex Community College

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 Chapter76

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 2 injections of Varicella, 2 injections of MMR, 3 injections of Hepatitis B, 1 injection of Tdap and 1 injection of MenACWY (21 years of age and younger) administered after 16th birthday. Proof of immunity by laboratory titer is acceptable for MMR, Hepatitis B and Varicella.

THIS SECTION TO BE COMPLETED BY THE MEDICAL PROVIDER

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

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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

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

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Tetanus/Diphtheria/Pertussis (Tdap): ___/___/_____ month/day/year

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Meningcoccal – MenACWY (21 years of age and younger/immunization administered after 16th birthday) ___/___/_____ month/day/year

Physician/Nurse Signature: _____ Print Last Name: _____

Address: _____ Phone: _____ Date: ___/___/_____ month/day/year

Signature by a physician is required unless immunization records are attached. Records need to be clearly identified and legible. Form revised 9/26/18