RETURN THIS FORM TO:

Student Development, MassBay Community College Fax number: 781-239-2669
[By Mail/In Person] 19 Flagg Drive - Room 316, Framingham, MA 01702-5928 Tel: 508-270-4014
[In Person] 50 Oakland Street- Room 130, Wellesley Hills, MA 02481-5307 Tel: 781-239-3142

MASSBAY COMMUNITY COLLEGE

STUDENT IMMUNIZATION RECORD

For General /Non-Health Sciences Students

Massachusetts state law requires all full-time students to submit the following immunizations or proof of immunity.
Your immunization records must be submitted within 30 days of the start of the semester.
Please have your healthcare provider complete and sign this form, or attach official immunization documents to this form.
Any attached records must be in English or include English translation.
For additional information regarding state requirements, please visit: https://www.mass.gov/service-details/school-immunizations

This form does not satisfy the immunization requirements for most Health Sciences programs.
Students pursuing admission to selective (criteria-based) programs must meet the requirements of Division of Health Sciences
http://www.massbay.edu/Academics/Health-Sciences/Health-and-Background-Check--Requirements.aspx

Last Name	First Name (Middle Initial)	Date of Birth
Date	**MassBay Student ID Number**	**Phone Number**

Enrolling Semester: ☐**FALL 20____** ☐**SPRING 20____** ☐**SUMMER 20____**

Required Vaccine	Dates Given	MA State Requirements
☐**MMR 2 doses** **-or-** **Measles, Mumps, and Rubella individual Vaccines** **-or-** **Positive titers**	#1___/___/___ #2___/___/___ -or- Measles #1___/___/__ #2___/___/___ Mumps ___/___/___ Rubella ___/___/___ -or- Measles Positive titer date:___/___/___ Mumps Positive titer date:___/___/___ Rubella Positive titer date:___/___/___	Two doses of MMR must be given at least four weeks apart beginning at or after 12 months of age. -or- Individual vaccines -or- Positive titer results
☐**Tdap** **-or-** **Td**	Tdap ___/___/___ -or- Td (if Tdap was given more than 10 years ago)___/___/___	One dose of Tdap, received any time at or after 7 years of age. If it has been more than 10 years since Tdap was given, a dose of Td.
☐**Hepatitis B 3 doses** **-or-** **Positive titer**	#1___/___/___ #2___/___/___ #3 ___/___/___ -or- Positive HepB AB titer date: ___/___/___	Three doses of Hepatitis B -or- Positive antibody titer result
☐**Varicella (Chicken Pox) 2 doses** **-or-** **Positive titer** **-or-** **History of disease**	#1___/___/___ #2___/___/___ -or- Positive titer date: ___/___/___ -or- History of disease: ___/___/___	Two doses of live varicella vaccine must be given at least four weeks apart beginning at or after 12 months of age. -or- Positive titer result -or- A reliable history of disease, signed by a healthcare provider
☐**Meningococcal: MenACWY** **-or-** **Signed waiver**	Date: ___/___/___ -or- Signed waiver: ☐ (please attach the signed form)	One dose of MenACWY(MCV4) for students 21 years of age or younger received on or after the 16th birthday. -or- Signed waiver. The form can be found: https://www.mass.gov/files/documents/2018/02/08/meningococcal-info-waiver.pdf

Healthcare provider signature: _____ **Date:** ___/___/___
Printed Name Signature
Profession/License No:_____