

# IMMUNIZATION RECORD

This form must be completed and signed by a health care provider

In accordance with Massachusetts College Immunization Law, Chapter 76, Section 15c, U Mass Lowell requires verification of immunity for measles, mumps, rubella, tetanus, diphtheria and hepatitis B. Exact dates are required for all immunizations and/or serologic test results. If serology titers indicate lack of immunity, vaccines must be administered. History of disease is not acceptable documentation of immunity.

Massachusetts Law (MGL Ch. 76, s.15D) now requires new full and part-time undergraduate and graduate students in degree granting programs at post-secondary institutions that provide or license housing to receive meningococcal vaccine. All new students, living on campus, must provide documentation of having received this vaccine (within the last five years) at least two weeks prior to the beginning of classes.

Student's Name \_\_\_\_\_  
Last First M.I. Date of Birth

## I. REQUIRED IMMUNIZATIONS

Month    Day    Year

### MMR (Measles, Mumps, Rubella)

Dose 1 Immunized on or after first birthday

Dose 1

Dose 2 Given at least one month after Dose 1

Dose 2

If unable to document MMR immunization dates, must provide:

\_\_\_\_\_  
 \_\_\_\_\_

### MEASLES (Rubeola)

Measles serology immune titer value \_\_\_\_\_

Interpretation:  Immune     Not Immune

Date:

\_\_\_\_\_  
 \_\_\_\_\_

### MUMPS

Mumps serology immune titer value \_\_\_\_\_

Interpretation:  Immune     Not immune

Date:

\_\_\_\_\_  
 \_\_\_\_\_

### RUBELLA

Rubella serology immune titer value \_\_\_\_\_

Interpretation:  Immune     Not immune

Date:

\_\_\_\_\_  
 \_\_\_\_\_

### TETANUS-DIPHTHERIA

Completed primary series of tetanus-diphtheria immunizations

Date:

Received tetanus-diphtheria booster within last 10 years

Date:

\_\_\_\_\_  
 \_\_\_\_\_

### HEPATITIS B

Completed series of Hepatitis B immunizations

Dose 1

Date:

Dose 2

Date:

Dose 3

Date:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

If unable to document Hepatitis B immunization dates, must provide:

Hepatitis B serology \_\_\_\_\_

Interpretation:  Immune     Not immune

Date:

\_\_\_\_\_  
 \_\_\_\_\_

### MENINGOCOCCAL VACCINE

Menactra    or     Menimune

Date:

\_\_\_\_\_  
 \_\_\_\_\_

## II. OTHER IMMUNIZATIONS

Varicella Vaccine    Dose 1    Month / Day / Year    Dose 2    Month / Day / Year    or titer    Month / Day / Year

### HEALTH CARE PROVIDER (Please print)

Name \_\_\_\_\_ Signature \_\_\_\_\_

Address \_\_\_\_\_ Telephone (\_\_\_\_\_) \_\_\_\_\_