



IMMUNIZATION RECORD | UMASS LOWELL

Name: _____ Date of Birth: _____

THIS FORM MUST BE COMPLETED AND SIGNED BY A MEDICAL PROVIDER.

ALTERNATIVELY, YOU MAY ATTACH A SIGNED FORM FROM YOUR MEDICAL OFFICE THAT MEETS ALL REQUIREMENTS BELOW.

In accordance with Massachusetts College Immunization Regulations, 105 CMR 220.600, U Mass Lowell requires verification of immunity for measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, varicella and Sars CoV-2. Exact dates are required for all immunizations and/or serologic test results. If serology titers indicate lack of immunity, vaccines must be administered.

HEPATITIS B	MMR <i>Measles, Mumps, Rubella</i>	VARICELLA <i>Chicken Pox</i>
<p>1. _____ <i>on or after 1st birthday</i></p> <p>3. _____ <i>at least one month after Dose 1</i></p> <p>3 _____ <i>at least six months after dose 1</i></p> <p><input type="checkbox"/> <u>Or</u> check here if 2-dose series, must include brand of 2-dose approved series with dates of dose 1 & 2 above</p> <p>Brand: _____</p> <p><input type="checkbox"/> <u>Or</u> Hep-B serology value: Hep-B (HBsAb): _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>	<p>1. _____ <i>on or after 1st birthday</i></p> <p>2 _____ <i>at least one month after Dose 1</i></p> <p><input type="checkbox"/> <u>Or</u> check here if born in USA before 1957, exception is students in health professions with patient contact</p> <p><input type="checkbox"/> <u>Or</u> MMR titer serology values: Measles: _____ circle one: immune / not immune Serology Date: _____ Mumps: _____ circle one: immune / not immune Serology Date: _____ Rubella: _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>	<p>1. _____ <i>on or after 1st birthday</i></p> <p>2. _____</p> <p><input type="checkbox"/> <u>Or</u> check here if born in USA before 1980, exception is students in health professions with patient contact</p> <p><input type="checkbox"/> <u>Or</u> if reliable history of disease documented by Health Care Provider: Disease Date: _____</p> <p><input type="checkbox"/> <u>Or</u> Varicella titer serology value: Varicella: _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>
TDAP/TD <i>Tetanus-Diphtheria-Acellular Pertussis / Tetanus-Diphtheria</i>	MENINGOCOCCAL <i>ACWY</i>	SARS-CoV-2 <i>Covid-19</i>
<p>TDAP: _____ <i>at least one dose of TDAP required</i></p> <p>TD: _____ <i>within past 10 years if TDAP >10 years ago</i></p>	<p>1. _____ <i>at age 16 or older for all incoming students 21 years of age or younger, OR signed waiver.</i></p> <p>Brand: _____</p> <p>Strains Covered: _____ Must Cover ACWY</p>	<p>1. _____</p> <p>2. _____</p> <p>3. _____</p> <p>Brand(s): _____ FDA or WHO approved vaccines only.</p>

Signature of Examiner Circle: MD, DO, NP, PA Date

Please Print Name of Examiner & Practice Location

Upload Completed and Signed Forms to the Student Health Portal: <https://patient-uml.medicatconnect.com/>

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