

# College of the Holy Cross Health Services

# Immunization Record

In accordance with MA state law, College of the Holy Cross requires all students to submit documentation of immunity to Health Services. The health care provider must complete this immunization record OR attach a copy of the student's immunization record on office stationary.

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

## REQUIRED VACCINES

<p><b>Measles, Mumps, Rubella (MMR)</b> 2 doses MMR Dose 1 after first birthday, Dose 2 at least 1 month after Dose 1 OR MMR immune serology (titer) accepted (attach lab documentation)</p>	<p><b>MMR</b> MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ OR Lab documentation attached _____</p>
<p><b>Hepatitis B</b> Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 wks. apart: at least 16 weeks between doses 1 and 3. OR Hepatitis immune serology (titer) accepted (attach lab documentation)</p>	<p><b>HEP B</b> MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ OR Lab documentation attached _____</p>
<p><b>Meningococcal vaccine</b> MA state law requires a dose after 16 yrs. of age. OR May choose to waive the vaccine. Must download and attach waiver.</p>	<p>MM/DD/YYYY Menomune Menactra or Dose 1 ____/____/____ Menveo Dose 2 ____/____/____ OR Waiver attached _____</p>
<p><b>Tetanus-Diphtheria and Pertussis (Tdap)</b> 1 dose within the past 10 years</p>	<p><b>Tdap</b> MM/DD/YYYY ____/____/____</p>
<p><b>Varicella vaccine (Chicken Pox)</b> 2 doses of Varicella at least 4 wks. apart after 12 months of age OR History of disease OR Varicella immune serology (titer) accepted</p>	<p><b>Varicella</b> MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ OR lab documentation attached _____ History of disease ____/____/____</p>
<p><b>Tuberculosis Screening</b> Complete Massachusetts DPH Tuberculosis Risk Assessment and submit with your health forms. If risk factor(s) present complete Interferon Gamma Release Assay (IGRA) or Tuberculin Skin Test (TST). IGRA: Date obtained ____/____/____ Specify method <input type="radio"/>GFT-GIT <input type="radio"/>T-spot Result: <input type="radio"/> Negative <input type="radio"/> Positive <input type="radio"/> Borderline (TSpot only) (attach lab)</p>	<p><b>Tuberculin Skin Test (TST):</b> MM/DD/YY Date given ____/____/____ Date read ____/____/____ Result ____ mm of induration Chest x-ray required if TST or IGRA is positive Date ____/____/____ <input type="radio"/> Normal <input type="radio"/> Abnormal Prophylactic Medication name: _____ Date started ____/____/____ Date ended ____/____/____</p>
<p><b>RECOMMENDED VACCINES:</b> <b>Human Papillomavirus (HPV)</b> 3 doses of HPV vaccine at 0,1-2, 6 month schedule age 9-26 yrs. OR 2 doses before 15<sup>th</sup> birthday at 0,6-12 months <b>Hepatitis A</b> 2 doses 6 months apart age 12 months and older <b>Meningitis B</b> Trumenba 2 or 3 dose schedule Bexsero 2 doses at least 1 month apart <b>Influenza</b> Seasonal vaccine, recommended annually <b>COVID 19</b> Two doses of Moderna or Pfizer, or one dose of J&amp;J Plus booster dose</p>	<p>MM/DD/YYYY <b>HPV</b> Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ <b>Hep A</b> Dose 1 ____/____/____ Dose 2 ____/____/____ <b>Trumenba</b> Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ <b>Bexsero</b> Dose 1 ____/____/____ Dose 2 ____/____/____ <b>Pneumococcal :</b> ____/____/____ <b>Influenza</b> ____/____/____ Moderna Dose1 ____ Dose 2 ____ Dose 3 ____ Pfizer Dose1 ____ Dose 2 ____ Dose 3 ____ J&amp;J Other _____</p>

Health Care Provider(print) \_\_\_\_\_ Signature \_\_\_\_\_

Address: \_\_\_\_\_ Phone # \_\_\_\_\_ Fax# \_\_\_\_\_