College of the Holy Cross Health Services **Immunization Record**

In accordance with Massachusetts 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 Immunizations

Requirement	Record
Measles, Mumps, Rubella (MMR) 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)	**MMR** MM /DD/YYYY Dose 1 ______/ _______/ _______ Dose 2 ______/ _______/ _______ OR Lab documentation attached _______
Hepatitis 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)	**HEP B** MM /DD/YYYY Dose 1 ______/ _______/ _______ Dose 2 ______/ _______/ _______ Dose 3 ______/ _______/ _______ OR Lab documentation attached _______
Meningococcal vaccine MA state law requires a dose after 16 yrs. of age. OR May choose to waive the vaccine. Must download and attach waiver.	MM /DD/YYYY Menomune Menactra or Dose 1 ______/ _______/ _______ Menveo Dose 2 ______/ _______/ _______ OR Waiver attached _______
Tetanus-Diptheria and Pertussis (Tdap) 1 dose within the past 10 years	**Tdap** MM /DD/YYYY ______/ _______/ _______
Varicella vaccine (Chicken Pox) 2 doses of Varicella at least 4 wks. apart after 12 months of age OR History of disease OR Varicella immune serology (titer) accepted (attach lab documentation)	**Varicella** MM /DD/YYYY Dose 1 ______/ _______/ _______ Dose 2 ______/ _______/ _______ OR Lab documentation attached _______ History of disease ______/ _______/ _______
Tuberculosis Screening 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 ◯GFT-GIT ◯ T-spot Result: ◯ Negative ◯ Positive ◯Borderline (TSpot only) (attach lab documentation)	**Tuberculin Skin Test (TST):** MM/DD/YY Date given ____/ ____/_____ Date read ____/____/____ Result _____ mm of induration Chest x-ray required if TST or IGRA is positive Date ____/____/____ ◯ Normal ◯ Abnormal Prophylactic Medication name: ____________________ Date started ____/____/____ Date ended ____/____/____
Other recommended vaccines: **Human Papillomavirus (HPV)** 3 doses of HPV vaccine at 0,1-2, 6 month schedule age 9-26 yrs. OR 2 doses before 15th birthday at 0,6-12 months **Hepatitis A** 2 doses 6 months apart age 12 months and older **Meningitis B** Trumemba 2 or 3 dose schedule Bexsero 2 doses at least 1 month apart Influenza Pneumococcal if high risk medical condition	MM /DD/YYYY **HPV** Dose 1 ______/ _______/ _______ Dose 2 ______/ _______/ _______ Dose 3 ______/ _______/ _______ **Hep A** Dose 1 ______/ _______/ _______ Dose 2 ______/ _______/ _______ **Trumenba** **Bexsero** Dose 1 ______/ _______/ ______ Dose 1 ______/ _______/ _____ Dose 2 ______/ _______/ ______ Dose 2 ______/ ______/ ______ Dose 3 ______/ _______/ ______ **Influenza** ______/ ______/ ______ **Pneumococcal** Name:__________________ _____/______/_____

Health Care Provider(print)____________________________ Signature _________________________________

Address: ____ Phone # _________________Fax# _____________