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 _____

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	**Varicella** MM /DD/YYYY Dose 1 _____/ _____/ _____ Dose 2 _____/ _____/ _____ OR lab documentation attached _____ History of disease _____/ _____/ _____
COVID 19 Two doses of Moderna or Pfizer, or one dose of J&J	**Moderna** Dose 1 _____/_____/_____ Dose 2 _____/_____/_____ **Pfizer** Dose 1 _____/_____/_____ Dose 2 _____/_____/____ **J&J** _____/_____/_____ Other_____
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** Trumenba 2 or 3 dose schedule Bexsero 2 doses at least 1 month apart **Influenza** Seasonal vaccine, recommended annually	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 _____/ _____/ _____ **Pneumococcal** Name:_____ _____/_____/_____ **Influenza** _____/_____/_____

Health Care Provider(print)_____ Signature _____

Address: _____ Phone # _____Fax# _____