BABSON/OLIN COLLEGE IMMUNIZATION RECORD

THIS FORM IS TO BE COMPLETED, SIGNED AND DATED BY YOUR HEALTH CARE PROVIDER

An official immunization record from your health care provider or school can be used in lieu of/or in conjunction with this form.

Student Name: ____ Date of Birth ____/____/____
Last First MI Month Day Year

In accordance with Massachusetts State Law (College Immunization Law, Chapter 76, Sections 15c and 15d) Babson College requires documentation of immunization or immunity to varicella, measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, and meningitis (ACWY). Documentation must include the exact dates for all immunizations or positive antibody titer. If antibody titer indicates a lack of immunity, vaccines must be administered.

REQUIRED VACCINES

Vaccines	*Dates Given*	*MA State Requirements*
COVID-19	#1___/___/___ #2___/___/___ *A positive anitbody titer will not fulfill the vaccine requirement*	Vaccine type: Circle the vaccine that was given or enter name Moderna, Pfizer, Johnson & Johnson, Astra Zeneca (**Circle one**) Other COVID 19 vaccine (please specify name of manufacturer):
Hepatitis B (3 doses) **OR** **Heplisav-B (2 doses)** *If Heplisav is given please indicate by circling the name*	#1___/___/___ #2___/___/___ #3___/___/___ **OR** Positive Titer Date ___/___/___ *Must include copy of lab report*	3 doses **OR** positive titer indicating immunity Min. of 4 weeks in between doses 1 & 2. Min. of 8 weeks between doses 2 & 3. Min of 16 weeks between doses 1 & 3. Heplisav-B doses a minimum of 4 weeks between doses 1 & 2.
MMR (2 doses)	#1___/___/___ #2___/___/___ **OR** Positive Titer Date___/___/___ *Must include copy of lab report*	1st dose must be given on or after 1st birthday. There must be a minimum of 4 weeks between doses 1 & 2. OR positive titers indicating immunity to all three diseases, measles, mumps and rubella.
Tdap	Tdap ___/___/___ Td ___/___/___	Tdap must be an adult tetanus, diphtheria, and acellular pertussis, it must have been given on or after age 10. Td immunization if Tdap was given after age 10 and was given ≥ 10 years ago.
Varicella	#1___/___/___ #2___/___/___ **OR** Positive Titer Date___/___/___ *Must include copy of lab report*	1st dose must be given on or after 1st birthday. There must be a minimum of 4 weeks between doses 1 & 2. **OR** positive titer indicating immunity. **Notation of having disease as a child is not acceptable, must show immunity to the disease via lab testing.**
***Meningococcal (ACWY)**	#1___/___/___ #2___/___/___ **OR** a signed State of Massachusetts Meningitis Vaccine Waiver Form	**Two doses required if dose 1 was given prior to 16th birthday.** **OR** signed State of Massachusetts Meningitis Vaccine Waiver form, ***This only applies to all students 21 years of age or younger***

RECOMMENDED/NOT REQUIRED VACCINES

Vaccines	*Dates Given*
Hepatitis A	#1___/___/___ #2___/___/___
HPV (Gardasil)	#1___/___/___ #2___/___/___ #3___/___/___
Meningococcal Group B **Bexsero or Trumenba** **(Please indicate which one was given)**	#1___/___/___ #2___/___/___
Influenza (Flu)	___/___/___

Health Care Provider's Signature____Date___/___/____

Health Care Provider's Address____

Health Care Provider's phone number ______________________ (include country code if outside of the US)

Revised 05/27/2021