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 CAN BE USED IN PLACE OF OR IN CONJUNCTION WITH THIS FORM

Student Name: ____ Date of Birth ____/____/____

Last First Middle Initial MM DD YY

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 (**ALL lab results MUST BE PROVIDED**). If antibody titer indicates a lack of immunity, vaccines must be administered. **THESE REQUIREMENTS APPLY TO ALL STUDENTS IN ANY FULL-TIME PROGRAM REGARDLESS OF AGE AND PART-TIME INTERNATIONAL STUDENTS ATTENDING BABSON ON ANY TYPE OF VISA.**

REQUIRED VACCINES

VACCINE	DATES GIVEN	MA STATE REQUIREMENTS
Hepatitis B (3 doses) OR Heplisav-B (2 doses) *If Heplisav was given, please indicate by circling its' name above.*	#1____/____/____#2____/____/____ #3____/____/____**OR** Positive Titer Date _____/____/____ ***Must include copy of lab report:*** **(Titer test is HBsAb Surface ANTIBODY)**	*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. ***Final dose cannot be given earlier than 24 weeks of age.** **Heplisav-B doses** (on or after Age 18): a minimum of 4 weeks between doses 1 & 2.
MMR (2 doses) **Titer test is the IgG test.**	#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 (**must provide lab report**) indicating **immunity to all three diseases**: measles, mumps, and rubella.
Tdap **Booster Dose (if last dose >10 years ago):**	#1 TDAP ___/___/___(on or after AGE 10) Booster Dose: #2 TDAP____/___/___**OR** TD ___/___/___	Tdap must be an adult tetanus, diphtheria, and acellular pertussis And must have been given **on or after age 10**. Td booster accepted if prior Tdap was given after age 10 and was given ≥ 10 years ago.
Varicella **Titer test is the IgG test.**	#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. You must show immunity to the disease via lab testing AND provide a copy of the report.**
***Meningococcal (ACWY)** **(Age 21 years or younger)**	#1____/____/____ **OR** a signed State of Massachusetts Meningitis Vaccine Waiver Form	**One dose required on or after your 16th birthday. OR** signed State of Massachusetts Meningitis Vaccine Waiver form. ***This requirement ONLY APPLIES to students 21 years of age or YOUNGER.**

STRONGLY RECOMMENDED VACCINES

VACCINES	DATES GIVEN
Meningococcal Group B	#1___/___/___ #2___/___/___ **Please CIRCLE which one was given**: BEXSERO TRUMENBA
Hepatitis A	#1___/___/___ #2___/___/___
HPV (Gardasil)	#1___/___/___ #2___/___/___ #3___/___/___
COVID-19	#1___/___/___#2___/___/___ #3___/___/___ #4___/___/___ **Vaccine Type: Please CIRCLE the vaccine that was given or ENTER NAME in space provided**: _______________________________ Moderna Pfizer Johnson & Johnson Astra Zeneca Novavax
Seasonal 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)