

BABSON 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, hepatitis B, influenza, and meningitis. 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
Hepatitis B (3 doses) OR Heplisav-B (2 doses) <i>If Heplisav is given please indicate by circling the name</i>	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ OR Positive Titer Date ____/____/____ <i>Must include copy of lab report</i>	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 ____/____/____ <i>Must include copy of lab report</i>	1st dose must be given on or after 1 st 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 ____/____/____ <i>Must include copy of lab report</i>	1st dose must be given on or after 1 st 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 applies to all students 21 years of age or younger*
**Seasonal Influenza (yearly)	____/____/____	Must have a current year seasonal influenza vaccine, State of MA requires all students to have a yearly flu vaccine. **Applies to all students <30 years of age.

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 ____/____/____
Yellow Fever	____/____/____
Japanese Encephalitis	#1 ____/____/____ #2 ____/____/____
Typhoid Oral (most recent)	____/____/____
Typhoid injectable (most recent)	____/____/____

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)