HAMPSHIRE COLLEGE HEALTH & COUNSELING SERVICES

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IMMUNIZATION FORM – TO BE COMPLETED BY HEALTHCARE PROVIDER

- **IMMUNIZATION RECORDS ARE REQUIRED.**
- Form must be completed and signed by healthcare provider who is not a family member.
- Submit records to Health Services by July 15 for fall term, and by January 15 for spring term.
- Records may be submitted via this form, faxed from your provider's office, or printed from patient portal.

Legal Name ______________________________________ Date of Birth ______ / ______ / ______
Last *First* *Middle Initial* *Month* *Day* *Year*

Chosen Name (if different) ______________________________

REQUIRED IMMUNIZATIONS (MUST BE COMPLETED BY HEALTHCARE PROVIDER)

- *The following immunizations are required by Massachusetts law. All dates must include month/day/year.*
- *If documentation of immunization is not available or if a blood test indicates that you are not immune, you must be re-immunized.*

Tdap – Tetanus, Diphtheria, Pertussis *One dose required within past 10 years.* **Tdap date** _______ /______ / _______ Month Day Year	**MMR – Measles, Mumps, Rubella** *Two doses required, at least one month apart, after 12 months of age.* **Dose 1** _____ /_____ / ______ **Dose 2** _____ /_____ / ______ Month Day Year Month Day Year **OR Positive Titer date*** _____ /_____ / _______ Month Day Year * Lab report for titer must accompany this form
Meningococcal (serogroup ACWY) **– Meningitis** Quadrivalent MCV4 (Menactra® or Menveo®) **Date** _______ /______ / _______ Month Day Year *One dose at age 16 or older for all incoming students age 21 or younger. Second dose highly recommended.* **OR** *Waiver available on health services website under student forms.*	**HEPATITIS B** **Check one:** ❑ 3 dose or ❑ 2 dose **Dose 1** _____ /_____ / ______ Month Day Year **Dose 2** _____ /_____ / ______ (must be at least one month after dose 1) Month Day Year **Dose 3** _____ /_____ / ______ Month Day Year (Dose 3 must be at least two months after #2 and four months after #1)
VARICELLA – Chicken Pox *Two doses (first dose after first birthday) or proof of disease required.* **Dose 1** _____ /_____ / ______ **Dose 2** _____ /_____ / ______ Month Day Year Month Day Year **OR Positive Titer, date*** _____ /_____ / _______ Month Day Year * Lab report for titer must accompany this form **OR History of disease** ❑Yes or ❑No **If yes, date of illness** _____ /_____ / _______ Month Day Year	**COVID-19 – Coronavirus*** ❑ **Pfizer, 2 doses** ❑ **Moderna, 2 doses** ❑ **J & J, 1 dose** ❑ **Other, _____ doses** **Dose 1** _____ /_____ / ______ **Dose 2** _____ /_____ / ______ Month Day Year Month Day Year * Requirements subject to change

IMPORTANT: Failure to comply with Massachusetts immunization law will result in hold being placed on student registration.

IMMUNIZATION FORM – TO BE COMPLETED BY HEALTHCARE PROVIDER

STRONGLY RECOMMENDED IMMUNIZATIONS (MUST BE COMPLETED BY HEALTHCARE PROVIDER)

- *The following immunizations are recommended for all incoming students.*
- *All dates must include month/day/year.*

HPV – Human Papilloma Virus

Three doses required at 0, 2, and 6 month intervals.

❑ **Gardasil®** ❑ **Other** ______________________

Dose 1 _____ /_____ / ______
Month Day Year

Dose 2 _____ /_____ / ______ (at least two months after dose 1)
Month Day Year

Dose 3 _____ /_____ / ______ (at least six months after dose 1)
Month Day Year

HEPATITIS A

Two doses required, at least six months apart.

Dose 1 _____ /_____ / ______
Month Day Year

Dose 2 _____ /_____ / ______ (at least six month after dose 1)
Month Day Year

MENINGITIS B

Two doses required, at least one month apart.

❑ **Bexsero®** ❑ **Trumenba®**

Dose 1 _____ /_____ / ______
Month Day Year

Dose 2 _____ /_____ / ______
Month Day Year

INFLUENZA, Seasonal (2021-2022)

Dose 1 _______ /_____ / _______
Month Day Year

PNEUMOCOCCAL VACCINE

The CDC recommends routine pneumococcal polysaccharide vaccination for adults with certain medical conditions including asthma, diabetes, and other chronic problems; those with compromised immune systems and those who smoke cigarettes.

❑ **Pneumovax®**

Dose 1 _______ /_____ / _______
Month Day Year

HEALTHCARE PROVIDER INFORMATION (SIGNATURE REQUIRED)

PROVIDER NAME (PRINT) ____

ADDRESS ____

PHONE ______________________________ FAX ____________________

PROVIDER SIGNATURE ______________________________ DATE ____________________

IMPORTANT: Failure to comply with Massachusetts immunization law will result in hold being placed on student registration.