

NOTE: ALL FORMS MUST BE SUBMITTED AS SOON AS POSSIBLE AND NO LATER THAN AUGUST 1ST FOR FALL ENTRY, JANUARY 1ST FOR SPRING ENTRY, AND MAY 1ST FOR SUMMER ENTRY

Name: _____ Date of Birth: _____ Identification #: _____

Springfield College Health Center
263 Alden Street / Springfield, MA 01109
(413) 748-3175 / (413) 748-3444 (fax)

IMMUNIZATION RECORD

PLEASE NOTE: Full clearance for registration **WILL NOT** be granted until **ALL** health requirements have been met. Immunization Record Information must be **COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER**. Shaded section is for Springfield College use only. Thank you.

REQUIRED IMMUNIZATIONS	DATE (M/D/Y)	EXEMPT MEDICAL	EXEMPT RELIGIOUS	EXEMPT WAIVER
HEPATITIS B #1 (Three doses of Hepatitis B vaccine OR a positive Hepatitis B Surface Antibody / Titer meets the requirement)				
HEPATITIS B #2 (Given 1 month after the first dose)				
HEPATITIS B #3 (Given 4 – 6 months after the first dose)				
HEPATITIS B SURFACE ANTIBODY / TITER RESULT (Circle one) Positive Negative				
MMR #1 (Two doses of MMR vaccine given at least 4 weeks apart beginning at or after 12 months of age OR a positive result to the Measles Antibody / Titer, Mumps Antibody / Titer, and Rubella Antibody / Titer meets the requirement)				
MMR #2 (Given ≥ 4 weeks after the first dose)				
MEASLES ANTIBODY / TITER RESULT (Circle one) Positive Negative				
MUMPS ANTIBODY / TITER RESULT (Circle one) Positive Negative				
RUBELLA ANTIBODY / TITER RESULT (Circle one) Positive Negative				
TETANUS (Single dose of Tdap if ≥ 5 years since last Td)				
VARICELLA HX OF DISEASE (Either clinician documented history of chickenpox disease, two doses of varicella vaccine given ≥ 4 weeks apart beginning at or after 12 months of age OR a positive Varicella Antibody / Titer meets the requirement)				
VARICELLA VACCINE #1 (Given at or after 12 months of age)				
VARICELLA VACCINE #2 (Given ≥ 4 weeks after the first dose)				
VARICELLA ANTIBODY / TITER RESULT (Circle one) Positive Negative				
MENINGOCOCCAL VACCINE Required for students who reside in ON-CAMPUS HOUSING (One dose of meningococcal polysaccharide vaccine within the last 5 years or a dose of meningococcal conjugate vaccine at anytime in the past)				

CLINICIAN'S SIGNATURE: _____ DATE: _____
 PRINTED NAME: _____
 CLINICIAN'S ADDRESS: _____
 TELEPHONE: _____

NOTE: If you are entering into the following **Health Science Programs: PA, OT, or PT**, you **must** provide proof of a Positive Varicella Titer or two Varicella Immunizations plus a current PPD prior to your Clinical Rotations.

- If you are entering into the **EMS Program**, you **must** provide proof of a Positive Hepatitis B Titer in addition to three Hepatitis B Immunizations, Positive Varicella Titer or two Varicella Immunizations, early childhood DPT and Polio Immunizations, Tetanus Immunization within 5 years, and a PPD within 6 months prior to Clinical Rotations.