

Name: _____ Date of Birth: _____ Identification Number: _____

Academic Program: _____ Year of Graduation: _____

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

IMMUNIZATION RECORD FOR SCHOOL OF HUMAN SERVICES STUDENTS

PLEASE NOTE: Full clearance for class registration **WILL NOT** be granted until **ALL** immunization 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 (Measles/Mumps/Rubella) 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 (Tetanus/Diphtheria/Pertussis) if ≥ 5 years since last Td (Tetanus/Diphtheria))				
VARICELLA HX OF DISEASE [Either clinician documented history of Varicella (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				

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

