

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 PART-TIME HEALTH SCIENCE 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 vaccine OR a positive Hepatitis B surface antibody / titer meets the requirement.)				
HEPATITIS B #2 (Students must at least BEGIN the series PRIOR to coming to campus.)				
HEPATITIS B #3				
HEPATITIS B SURFACE ANTIBODY / TITER RESULT (Circle one) Positive Negative				
MEASLES #1 (Part of MMR. Given at age 12 – 15 months or later.) Two doses of vaccine OR a positive Measles antibody / titer meets the requirement.				
MEASLES #2 (Part of MMR. Given at age 4 – 6 years or later and at least 1 month after the first dose.)				
MEASLES ANTIBODY / TITER RESULT (Circle one) Positive Negative				
MUMPS (Part of MMR. Given at age 12 months or later) One dose of vaccine OR a positive Mumps antibody / titer meets the requirement.				
MUMPS ANTIBODY / TITER RESULT (Circle one) Positive Negative				
RUBELLA (Part of MMR. Given at age 12 months or later.) One dose of vaccine OR a positive Rubella antibody / titer meets the requirement.				
RUBELLA ANTIBODY / TITER RESULT (Circle one) Positive Negative				
TETANUS (Booster with Td in the last 10 years meets the requirement.)				

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