

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 vaccine OR a positive Hepatitis B surface antibody / titer meets the requirement.)				
HEPATITIS B #2				
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.)				
VARICELLA ANTIBODY / TITER (Either a history of Chicken Pox OR a positive Varicella antibody / titer OR two doses of vaccine given at least one month apart if immunized after 13 years of age meets the requirement.)				
HISTORY OF VARICELLA (CHICKEN POX)				
VARICELLA VACCINE #1				
VARICELLA VACCINE #2 (Given at least one month after first dose if age 13 years or older.)				
MENINGOCOCCAL VACCINE Required for students who reside in ON-CAMPUS HOUSING (One dose. Students with immunodeficiency such as complement deficiency or asplenia should receive vaccine every 3 – 5 years.)				

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

TELEPHONE: _____