



IMMUNIZATION RECORD | UMASS LOWELL

Name: _____ Date of Birth: _____

THIS FORM MUST BE COMPLETED AND SIGNED BY A MEDICAL PROVIDER.

ALTERNATIVELY, YOU MAY ATTACH A SIGNED FORM FROM YOUR MEDICAL OFFICE THAT MEETS ALL REQUIREMENTS BELOW.

In accordance with Massachusetts College Immunization Regulations, 105 CMR 220.600, UMass Lowell requires verification of immunity for measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, and varicella. Exact dates are required for all immunizations and/or serology test results. If serology titers indicate lack of immunity, vaccines must be administered.

HEPATITIS B	MMR <i>Measles, Mumps, Rubella</i>	VARICELLA <i>Chicken Pox</i>
<p>1. _____ _____</p> <p>3. _____ <i>at least one month after Dose 1</i></p> <p>3 _____ <i>at least six months after dose 1</i></p> <p><input type="checkbox"/> <u>Or</u> check here if 2-dose series, must include brand of 2-dose approved series with dates of dose 1 & 2 above</p> <p>Brand: _____</p> <p><input type="checkbox"/> <u>Or</u> Hep-B serology value: Hep-B (HBsAb): _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>	<p>1. _____ <i>on or after 1st birthday</i></p> <p>2 _____ <i>at least one month after Dose 1</i></p> <p><input type="checkbox"/> <u>Or</u> check here if born in USA before 1957, exception is students in health professions with patient contact</p> <p><input type="checkbox"/> <u>Or</u> MMR titer serology values: Measles: _____ circle one: immune / not immune Serology Date: _____ Mumps: _____ circle one: immune / not immune Serology Date: _____ Rubella: _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>	<p>1. _____ <i>on or after 1st birthday</i></p> <p>2. _____</p> <p><input type="checkbox"/> <u>Or</u> check here if born in USA before 1980, exception is students in health professions with patient contact</p> <p><input type="checkbox"/> <u>Or</u> if reliable history of disease documented by Health Care Provider: Disease Date: _____</p> <p><input type="checkbox"/> <u>Or</u> Varicella titer serology value: Varicella: _____ circle one: immune / not immune Serology Date: _____ Must include report with laboratory value</p>
TDAP <i>Tetanus-Diphtheria-Acellular Pertussis</i>		MENINGOCOCCAL <i>ACWY</i>
<p>TDAP: _____ <i>One dose of TDAP required every 10 years</i></p>		<p>1. _____ <i>at age 16 or older for all incoming students 21 years of age or younger, OR signed waiver.</i></p> <p>Brand: _____</p> <p>Strains Covered: _____ Must Cover ACWY</p>

Signature of Examiner Circle: MD, DO, NP, PA Date

Please Print Name of Examiner & Practice Location

Upload Completed and Signed Forms to the Student Health Portal: <https://patient-uml.medicatconnect.com/>

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