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 serologic test results. If serology titers indicate lack of immunity, vaccines must be administered.

HEPATITIS B	**MMR** *Measles, Mumps, Rubella*	**VARICELLA** *Chicken Pox*
1. ______/______/______ 3. ______/______/______ *at least one month after Dose 1* 3 ______/______/______ *at least six months after dose 1* ☐ *Or* check here if 2-dose series, ***must include brand of 2-dose approved series with dates of dose 1 & 2 above*** Brand: ________________________ ☐ *Or* Hep-B serology ***value***: **Hep-B** (HBsAb): ________ circle one: immune / not immune Serology Date: ____/____/____ ***Must include report with laboratory value***	1. ______/______/______ *on or after 1st birthday* 2 ______/______/______ *at least one month after Dose 1* ☐ *Or* check here if born in USA before 1957, ***exception is students in health professions with patient contact*** ☐ *Or* 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***	1. ______/______/______ *on or after 1st birthday* 2. ______/______/______ ☐ *Or* check here if born in USA before 1980, ***exception is students in health professions with patient contact*** ☐ *Or* if reliable history of disease documented by Health Care Provider: Disease Date: ____/____/____ ☐ *Or* Varicella titer serology ***value***: **Varicella:** ________ circle one: immune / not immune Serology Date: ____/____/____ ***Must include report with laboratory value***

TDAP *Tetanus-Diptheria-Acellular Pertussis*	**MENINGOCOCCAL** *ACWY*	
Tdap:______/______/______ *One dose on or after your 11th birthday is required.* Additional doses (boosters) of Tdap or Td not required, but highly recommended every 10 years. Last booster dose: ______________ Last booster type (circle): **Td** **Tdap**	1. ______/______/______ *at age **16** or older for all incoming students **21 years of age or younger, OR** signed waiver.* Brand: ______________________ Strains covered:______________ **Must cover ACWY**	

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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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