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, U Mass Lowell requires verification of immunity for measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B, varicella and Sars CoV-2. 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. _____/_____/_____	1. _____/_____/_____ *on or after 1st birthday*	1. _____/_____/_____ *on or after 1st birthday*
3. _____/_____/_____ *at least one month after Dose 1*	2 _____/_____/_____ *at least one month after Dose 1*	2. _____/_____/_____
3 _____/_____/_____ *at least six months after dose 1*	☐ *Or* check here if born in USA before 1957, ***exception is students in health professions with patient contact***	☐ *Or* check here if born in USA before 1980, ***exception is students in health professions with patient contact***
☐ *Or* check here if 2-dose series, ***must include brand of 2-dose approved series with dates of dose 1 & 2 above***	☐ *Or* MMR titer serology ***values***:	☐ *Or* if reliable history of disease documented by Health Care Provider: Disease Date: ____/____/_____
Brand: _____	**Measles:** _____ circle one: immune / not immune Serology Date: ____/____/_____	☐ *Or* Varicella titer serology ***value***:
☐ *Or* Hep-B serology ***value***:	**Mumps:** _____ circle one: immune / not immune Serology Date: ____/____/_____	**Varicella:** _____ circle one: immune / not immune Serology Date: ____/____/_____
Hep-B (HBsAb): _____ circle one: immune / not immune Serology Date: ____/____/_____	**Rubella:** _____ circle one: immune / not immune Serology Date: ____/____/_____	***Must include report with laboratory value***
Must include report with laboratory value	***Must include report with laboratory value***	

TDAP *Tetanus-Diptheria-Acellular Pertussis*	MENINGOCOCCAL *ACWY*	
TDAP: _____/_____/_____ *One dose of TDAP required every 10 years*	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***	

_____ _____

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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