



# 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 <i>Measles, Mumps, Rubella</i>	VARICELLA <i>Chicken Pox</i>
<p>1. _____ <i>on or after 1<sup>st</sup> birthday</i></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, <b>must include brand of 2-dose approved series with dates of dose 1 &amp; 2 above</b></p> <p>Brand: _____</p> <p><input type="checkbox"/> <u>Or</u> Hep-B serology <b>value:</b>  <b>Hep-B (HBsAb):</b> _____  circle one: immune / not immune  Serology Date: _____  <b>Must include report with laboratory value</b></p>	<p>1. _____ <i>on or after 1<sup>st</sup> 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, <b>exception is students in health professions with patient contact</b></p> <p><input type="checkbox"/> <u>Or</u> MMR titer serology <b>values:</b>  <b>Measles:</b> _____  circle one: immune / not immune  Serology Date: _____  <b>Mumps:</b> _____  circle one: immune / not immune  Serology Date: _____  <b>Rubella:</b> _____  circle one: immune / not immune  Serology Date: _____  <b>Must include report with laboratory value</b></p>	<p>1. _____ <i>on or after 1<sup>st</sup> birthday</i></p> <p>2. _____</p> <p><input type="checkbox"/> <u>Or</u> check here if born in USA before 1980, <b>exception is students in health professions with patient contact</b></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 <b>value:</b>  <b>Varicella:</b> _____  circle one: immune / not immune  Serology Date: _____  <b>Must include report with laboratory value</b></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: _____ <b>Must Cover ACWY</b></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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