

Name \_\_\_\_\_ Class \_\_\_\_\_ DOB \_\_\_\_\_

## LASELL UNIVERSITY IMMUNIZATION RECORD

*This form must be completed and signed by a health care provider*

### REQUIRED VACCINES

**\*Official form from provider's office also acceptable**

Vaccines	Dates Given	MA State Requirements
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date ___/___/___	3 doses <b>OR</b> positive titer  Minimum of 1 month between doses 1 & 2 Minimum of 4 months between doses 1 & 3
Meningococcal (ACWY)	#1 ___/___/___ <input type="checkbox"/> Menactra <input type="checkbox"/> Menveo	One dose within past 5 years for all new Freshmen and Transfer students. <b>Must be after 16th birthday.</b>
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date ___/___/___	*1st dose must be given after 1st birthday. Minimum of 4 weeks between doses.
Tdap/Td	Tdap ___/___/___ Td ___/___/___	1 Tdap after age 6 and either Tdap or Td within past 10 years.
Varicella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date ___/___/___ OR History of Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, approx. date ___/___/___	2 doses <b>OR</b> positive titer. 1st dose must be given after 1st birthday. Minimum of 4 weeks between doses.

### RECOMMENDED/OPTIONAL VACCINES

Vaccines	Dates Given	MA State Requirements
Hepatitis A	#1 ___/___/___ #2 ___/___/___	Recommended if planning travel Interval: 6-12 months between doses 1 & 2
Hib	#1 ___/___/___	Primary Series
HPV	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Health care maintenance
Influenza	Most Recent: #1 ___/___/___	Recommended Annually
Meningococcal B (Bexsero)	#1 ___/___/___ #2 ___/___/___	Minimum of 1 month between doses
Pneumococcal	#1 ___/___/___ <input type="checkbox"/> Polysaccharide (PPV) <input type="checkbox"/> Conjugate(PCV)	Chronic Health Problems
Polio	Primary series: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable Most Recent Booster ___/___/___	Primary Series
Typhoid	<input type="checkbox"/> Oral <input type="checkbox"/> Injectable	Travel
Yellow Fever	#1 ___/___/___	Travel

**SIGNATURE OF HEALTHCARE**

**PROVIDER** \_\_\_\_\_

PRINT

SIGNATURE

DATE