



Last Name

First Name

Date of Birth

Student ID #

(617) 287-5660 [www.umb.edu/healthservices](http://www.umb.edu/healthservices)

## Immunization Form 2023-2024

**This form must be filled out by a healthcare provider and then uploaded to the My Health Beacon portal.**

**After this form is completed and signed/stamped by a healthcare provider (see page 4):**

1. Login to My Health Beacon portal at <https://www.umb.edu/health-services/my-health-beacon-portal/>
2. Complete the web-based TB Risk Screen questionnaire. For instructions visit [https://www.umb.edu/healthservices/screening\\_clinics/uploading\\_documentation](https://www.umb.edu/healthservices/screening_clinics/uploading_documentation)
3. Next, go to the Medical Clearance page and select Immunization Records. Upload this form and all supporting documents (immunization and titer records). **If you do not have supporting documentation, this form MUST be signed and stamped by your health care provider.**

For instructions on how to upload documents please visit

[https://www.umb.edu/healthservices/screening\\_clinics/uploading\\_documentation](https://www.umb.edu/healthservices/screening_clinics/uploading_documentation)

**\*Please note: For all titers, a lab report must be submitted with this form, or your result will not be accepted.**

Alternatively, fax this form to the University Health Services at (617) 287-3977, or mail to:

*University of Massachusetts Boston  
University Health Services  
100 Morrissey Blvd  
Boston, MA 02125*

Massachusetts state law requires submission of certain immunizations or proof of immunity for college attendance. All vaccine requirements are subject to legally recognized medical and religious accommodations. Please visit [https://www.umb.edu/healthservices/screening\\_clinics/exemptions](https://www.umb.edu/healthservices/screening_clinics/exemptions) for guidance on how to apply for an exemption.

*Students born in the U.S. before 1957 are exempt and considered immune from measles, mumps, rubella, and varicella (exemption does not apply to CNHS students).*

**Required Immunizations**

Required Vaccines	Dates Given (mm / dd / yyyy)	Massachusetts Vaccine Requirements
MenACWY or MCV4 (Meningococcal Conjugate)	Dose: / /	One dose is required for full-time students 21 years or younger. Dose must have been administered <u>on or after</u> your 16 <sup>th</sup> birthday. Doses administered before age 16 do not count.
Tdap (Tetanus, diphtheria, & acellular pertussis)  <i>Select vaccine formula by checking the appropriate box</i> 1 <sup>st</sup> Dose: <input type="checkbox"/> DTaP <input type="checkbox"/> DT 2 <sup>nd</sup> Dose: <input type="checkbox"/> DTaP <input type="checkbox"/> DT 3 <sup>rd</sup> Dose: <input type="checkbox"/> DTaP <input type="checkbox"/> DT 4 <sup>th</sup> Dose: <input type="checkbox"/> DTaP <input type="checkbox"/> DT 5 <sup>th</sup> Dose: <input type="checkbox"/> DTaP <input type="checkbox"/> DT	Dose: / /  <i>DTaP Childhood history; primary series</i> 1 <sup>st</sup> Dose (2 mos.): / / 2 <sup>nd</sup> Dose (4 mos.): / / 3 <sup>rd</sup> Dose (6 mos.): / / 4 <sup>th</sup> Dose (15-18 mos.): / / 5 <sup>th</sup> Dose (4-6 yrs.): / /	One dose and history of a DTaP primary series or age-appropriate catch-up vaccination. Dose must have been administered on or after 7 <sup>th</sup> birthday.
Td (Tetanus & diphtheria)	Dose: / /	A booster dose is required every 10 years after an age-appropriate dose of a vaccine containing Td antigens. A Tdap vaccine will be accepted for this requirement if Td is not available.
MMR (Measles, Mumps, Rubella)  -or-  MMRV (Measles, Mumps, Rubella, Varicella)  -or-  Positive titer Measles IgG  Positive titer Mumps IgG  Positive titer Rubella IgG	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / /  -or-  1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / /  -or-  Date test performed: / /  Date test performed: / /  Date test performed: / /	Two doses at least 28 days apart and 1 <sup>st</sup> dose given on or after 1 <sup>st</sup> birthday.           Positive titer (antibody IgG) of measles, mumps, and rubella. All three must have a positive result* or 2 doses of the MMR vaccine are required. <b>*You must attach a copy of the lab report. Results will not be accepted without a lab report.</b>
Hep B (Hepatitis B) <i>Select vaccine formula by checking the appropriate box</i> <input type="checkbox"/> Engerix-B/Recombivax /other 3-dose Hep B series  -or- <input type="checkbox"/> Heplisav-B (2-doses)  -or-  Date test performed: / /	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / / 3 <sup>rd</sup> dose: / /	Three doses of Hepatitis B vaccine. Minimum of 28 days between 1 <sup>st</sup> & 2 <sup>nd</sup> dose; six months between 1 <sup>st</sup> & 3 <sup>rd</sup> dose.  -or-  Two doses of Heplisav-B (at least 28 days apart) for persons aged 18 and older.  -or-  Positive Hep B surface antibody IgG (ant-HBs) * <b>*You must attach a copy of the lab report. Results</b>

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Positive Hepatitis B titer (anti-HBs)		<i>will not be accepted without a lab report.</i>
Varicella (Chickenpox)	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / /	Two doses at least 28 days apart and 1 <sup>st</sup> dose given on or after 1 <sup>st</sup> birthday (12 months)
-or-	-or-	
MMRV (Measles, Mumps, Rubella, Varicella)	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / /	
-or-	-or-	-or-
Positive titer VZV IgG	Date test performed: / /	Positive Varicella titer (antibody IgG) *
-or-	-or-	<i>*You must attach a copy of the lab report. Results will not be accepted without a lab report.</i>
Confirmed history of varicella illness	Date of illness onset: / /	

### Highly Recommended Immunizations

Recommended Vaccines	Dates Given (mm / dd / yyyy)	CDC & MDPH Recommendations
Influenza (Flu)	Dose: / /	One dose is recommended annually for all college students. CNHS students are required to have the influenza vaccine annually during clinicals.
COVID-19 Vaccine (Bivalent) <i>Select vaccine formula by checking box</i> <input type="checkbox"/> Pfizer <input type="checkbox"/> Moderna	Dose: / /	One updated Pfizer or Moderna vaccine is recommended, regardless of whether an original COVID-19 vaccine was administered.
Men B (Meningococcal Serotype B) <i>Select vaccine formula by the checking the appropriate box</i> <input type="checkbox"/> Bexero (2-doses) <input type="checkbox"/> Trumenba (2 or 3 doses)	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / / 3 <sup>rd</sup> dose: / /	The Men B vaccine may be administered to adolescents and young adults aged 16–23 years to provide short-term protection against most strains of serogroup B meningococcal disease. Trumenba offers a 2-dose option for healthy individuals not at increased risk for Men B.
HPV (Human Papillomavirus)	1 <sup>st</sup> dose: / / 2 <sup>nd</sup> dose: / / 3 <sup>rd</sup> dose*: / /  <i>*Individuals younger than 15 years of age who receive 2-doses less than 5 months</i>	HPV is a common sexually transmitted infection. There are different types of HPV. Some types can cause health problems, such as genital warts and cancers. The HPV vaccine is safe, effective, and can protect against diseases (including cancers) caused by the HPV. 2-doses (6 to 12 months apart) are recommended for adolescents who start the vaccine before their 15 <sup>th</sup> birthday. 3-doses are recommended for individuals who start the series at age 15 or older,



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	apart will require a 3 <sup>rd</sup> dose.	and for immunocompromised persons.
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**Healthcare Provider's Signature (MD/OD/PA/NP/RN) (Required)**

Printed name of healthcare provider: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_

Name of healthcare facility: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

**Official provider or institutional stamp:  
(Required)**