



**School of Dental Medicine Immunization Form**  
*Boston Health Sciences Campus ~ Student Advisory & Health Administration Office*

Name: \_\_\_\_\_  
 Last First Middle Date of Birth

Address: \_\_\_\_\_  
 Street Apt. City, State, Zip Code

Program (s): \_\_\_\_\_ Class: \_\_\_\_\_ Tufts University I.D. Number: \_\_\_\_\_  
 DMD, DPG, MS, GPR or IS

**Required Immunizations:**

<p><b>Tetanus Diphtheria Acellular Pertussis (Tdap):</b> One dose of Tdap vaccine is required, in lieu of Td.           If current Td is less than 2 years, wait to receive Tdap vaccine.  <b>Record Td Vaccine Date:</b> _____</p>	<p><b>Tdap Vaccine Date:</b> _____</p>
<p><b>Measles, Mumps and Rubella:</b> 2 doses of MMR vaccine or positive antibody titers.</p>	<p><b>MMR #1 Date:</b> _____ <b>MMR #2 Date:</b> _____          OR  <b>Measles Antibody Titer Date:</b> _____ <b>Result:</b> _____  <b>Mumps Antibody Titer Date:</b> _____ <b>Result:</b> _____  <b>Rubella Antibody Titer Date:</b> _____ <b>Result:</b> _____</p>
<p><b>Tuberculosis Mantoux Test:</b> Required within one year prior to first year registration and required annually thereafter.           A history of BCG vaccine is not acceptable as proof of being tuberculin positive. BCG recipients must provide documentation of a tuberculosis test. If tuberculin positive, a chest X-ray received within one year prior to first year registration is required. List history of BCG vaccine and/or INH treatment.</p>	<p><b>Test Date:</b> _____ <b>#mm Induration:</b> _____ <b>Result:</b> _____   <i>If TB positive, a Chest x-ray is required within one year prior to first year registration.</i>  <b>Chest x-ray Date:</b> _____ <b>Result:</b> _____  <b>BCG Vaccine Date:</b> _____  <b>INH Treatment Dates:</b> _____ to _____</p>
<p><b>Varicella (Chicken Pox):</b> Year of disease, vaccination, or positive antibody titer. Physician verification not required for year of disease.</p>	<p><b>Year of Disease:</b> _____  <b>#1 Date:</b> _____ <b>#2 Date:</b> _____  <b>Antibody titer Date:</b> _____ <b>Result:</b> _____</p>
<p><b>Hepatitis B:</b> See Hepatitis B Documentation Form on page 2.</p>	<p><b>Hepatitis B:</b> See Hepatitis B Documentation Form on page 2.</p>
<p><b>Meningococcal:</b> One dose of vaccine given within the past five years of start date or a signed State Waiver Form for all first year students. (<i>State Waiver Form available at: <a href="http://www.tufts.edu/saha">www.tufts.edu/saha</a></i>)</p>	<p><b>Vaccine Date:</b> _____ <b>or Submit State Waiver Form</b></p>
<p><b>Polio:</b> Documentation of vaccination is recommended. Proof of vaccination may be required in the future.</p>	<p><b>Salk:</b> _____  <b>Sabin:</b> _____</p>

*State requirements under 105 CMR 220.660 shall not apply where: (1) the student provides written documentation that he or she meets the standards for medical or religious exemption set forth in M.G.L.c.76, 15C.*

Signature: \_\_\_\_\_ **OR Attach other immunization documentation**  
 Health Care Professional

Name (Please Print): \_\_\_\_\_ Date: \_\_\_\_\_

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

**Please fax or mail immunization documentation to: Fax: 617-636-2708 – Phone: 617-636-2700**  
 200 Harrison Avenue, Posner Hall 4<sup>th</sup> Floor, Boston, MA 02111 - [www.tufts.edu/saha](http://www.tufts.edu/saha)



## School of Dental Medicine Hepatitis B Documentation Form

Tufts University School of Dental Medicine requires testing for presence of infection and immunity to Hepatitis B prior to matriculation. Testing for the presence of infection (HbsAg) is required prior to vaccination or if restarting the series. Testing for immunity (anti-HBs) is required within 6 months following the three doses of vaccine. Applicants who test positive for the presence of surface antigen (HBsAg) must also provide test results for HBV DNA. **Applicants who test positive for the presence of both surface antigen (HBsAg) and HBV DNA will not be allowed to matriculate in the Tufts University School of Dental Medicine due to the invasive nature of dental procedures and the communicability of the Hepatitis B virus.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

Program: \_\_\_\_\_  
DMD, DPG, MS, GPR or IS

Class: \_\_\_\_\_

Tufts I.D. # \_\_\_\_/\_\_\_\_/\_\_\_\_

**Please read the following, as more than one may apply to you.**

**Step I. Obtain Hepatitis B surface antigen titer (HBsAg test for infection):** Required if student has not started or completed the series.

A. HBsAg Titer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle Result: Negative Positive (Attach Laboratory Report)

If HBsAg **negative**, begin or finish the Hepatitis B vaccine series, Step II, and complete Step III.

If HBsAg **positive**, obtain an HBV DNA test.

B. HBV DNA test Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle Result: Negative Positive (Attach Laboratory Report)

If HBV DNA **negative**, applicants are allowed to matriculate. Vaccination is not required.

If HBV DNA **positive**, applicants are not allowed to matriculate.

**Step II. Obtain Hepatitis B Vaccine:** Three doses of vaccine. Protocol: day 1, 2 months, 6 months.

A. Dose #1 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #2 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Dose #3 Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Step III. Obtain Hepatitis B surface antibody titer (Anti-HBs test for immunity) within 2-6 months following the three-dose series.**

If you completed the series previously, obtain a Hepatitis B surface antibody.

A. Anti-HBs Titer Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Circle Result: Negative Positive (Attach Laboratory Report)

If Anti-HBs **positive**, no additional testing or vaccination required. You are immune to Hepatitis B.

If Anti-HBs **negative and Step I was skipped**, obtain an HBsAg titer.

If HBsAg **negative**, restart the series or obtain booster dose(s) following the protocol recommended by your physician.  
Note: another antibody titer is required after additional dose(s).

If HBsAg is **positive** see Step I-B.

\_\_\_\_\_  
Physician or Nurse Signature

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone #

**Return completed form and laboratory reports to:** Student Advisory & Health Administration Office  
200 Harrison Avenue, Boston, MA 02111 Fax: 617-636-2708 Phone: 617-636-2700