



School of 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: _____
 MD, MD/PHD or RCP

Required Immunizations:

<p>Tetanus Diphtheria Acellular Pertussis (Tdap): One dose of Tdap vaccine is required, in lieu of Td. If current Td is less than 2 years wait to receive Tdap vaccine. Record Td Vaccine Date: _____</p>	<p>Tdap Vaccine Date: _____</p>
<p>Measles, Mumps and Rubella: Positive antibody titers required. Laboratory report must be attached. Dates of immunization should be recorded, but will not substitute for antibody titers.</p>	<p>Measles Antibody Titer Date: _____ Result: _____ Mumps Antibody Titer Date: _____ Result: _____ Rubella Antibody Titer Date: _____ Result: _____ MMR #1 Date: _____ MMR #2 Date: _____</p>
<p>Tuberculosis Mantoux Test: 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>Test Date: _____ #mm Induration: _____ Result: _____ <i>If TB positive, a Chest x-ray is required within one year prior to first year registration.</i> Chest x-ray Date: _____ Result: _____ BCG Vaccine Date: _____ INH Treatment Dates: _____ to _____</p>
<p>Varicella (Chicken Pox): Positive antibody titer. If antibody titer is negative or equivocal, 2 doses of varicella vaccine are required. Laboratory report must be attached. Dates of immunization should be recorded, but will not substitute for antibody titers.</p>	<p>Antibody Titer Date: _____ Result: _____ Year of Disease: _____ #1 Date: _____ #2 Date: _____</p>
<p>Polio: Documentation of childhood vaccination is required.</p>	<p>Salk: _____ Sabin: _____</p>
<p>Hepatitis B: Positive antibody titer. If antibody titer is negative or equivocal restart 3 dose series. When series is completed repeat antibody titer within 2 to 6 months. Laboratory report must be attached. Dates of immunization should be recorded, but will not substitute for antibody titers.</p>	<p>Antibody Titer Date: _____ Result: _____ #1 Date: _____ #2 Date: _____ #3 Date: _____ Booster Dose Date: _____ <i>If needed</i></p>
<p>Meningococcal: 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: www.tufts.edu/saha</i>)</p>	<p>Vaccine Date: _____ or Attach State Waiver Form</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 4th Floor, Boston, MA 02111 - www.tufts.edu/saha**