Friedman School of Nutrition Science and Policy 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): _____ **Tufts University I.D. Number:** _____

Required Immunizations:

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:** _____	**Tdap Vaccine Date:** _____
Measles, Mumps and Rubella: 2 doses of MMR vaccine or positive antibody titers.	**MMR #1 Date:** _____ **MMR #2 Date**: _____ **OR** **Measles Antibody Titer Date:** _____ **Result:** _____ **Mumps Antibody Titer Date:** _____ **Result:** _____ **Rubella Antibody Titer Date:** _____ **Result:** _____
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.	**Test Date:** _____ **#mm Induration:** _____ **Result:** _____ *If TB positive, a Chest x-ray is required within one year prior to first year registration***.** **Chest x-ray Date:** _____ **Result:** _____ **BCG Vaccine Date:** _____ **INH Treatment Dates:** _____ to _____
Varicella (Chicken Pox): Year of disease, vaccination, or positive antibody titer. Physician verification not required for year of disease.	**Year of Disease:** _____ **#1 Date:** _____ **#2 Date:** _____ **Antibody titer Date**: _____ **Result:** _____
Hepatitis B: Vaccination or positive antibody titer. Testing for immunity, 2 to 6 months after vaccination is recommended.	**#1 Date:** _____ **#2 Date:** _____ **#3 Date:** _____ **Booster Dose Date**: _____ *If needed* **Antibody Titer Date:** _____ **Result:** _____
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. (*State Waiver Form available at: www.tufts.edu/saha*)	**Vaccine Date:** _____ **or Submit State Waiver Form**
Polio: Documentation of vaccination is recommended. Proof of vaccination may be required in the future.	**Salk:** _____ _____ _____ **Sabin:** _____ _____ _____

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