



**Cummings School of Veterinary Medicine Immunization Form**  
*Grafton Health Sciences Campus ~ Student Advisory & Health Administration Office*

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

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

Program (s): \_\_\_\_\_  
 DVM, MS, PHD, CBS or Ross

Tufts University I.D. Number: \_\_\_\_\_

**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>Varicella (Chicken Pox):</b> Year of disease or did not have disease. Physician verification is not required for year of disease.</p>	<p><b>Year of Disease:</b> _____ OR <b>Did not have:</b> _____  <b>#1 Date:</b> _____ <b>#2 Date:</b> _____  <b>Antibody titer Date:</b> _____ <b>Result:</b> _____</p>
<p><b>Rabies Vaccination</b>   <b>DVM, CBS and Ross:</b> Pre-exposure vaccination or positive antibody.   <b>MS and PhD:</b> Pre-exposure vaccination or positive antibody titer for students who work with animals or live rabies virus.           If initial vaccination, booster dose, or antibody titer is 2 years old, a new antibody titer is required. If titer level is insufficient for immunity, a booster dose is required. <b>Laboratory report must be attached.</b></p>	<p><b>#1 Date:</b> _____ <b>#2 Date:</b> _____ <b>#3 Date:</b> _____  <b>Antibody Titer Date:</b> _____ <b>Result:</b> _____          If antibody titer is less than 0.5 IU/mL you need a booster dose.  <b>Booster Dose Date:</b> _____ <i>If needed</i></p>
<p><b>Hepatitis B:</b> Vaccination or positive antibody titer. Testing for immunity, 2 to 6 months after vaccination is recommended.</p>	<p><b>#1 Date:</b> _____ <b>#2 Date:</b> _____ <b>#3 Date:</b> _____  <b>Booster Dose Date:</b> _____ <i>If needed</i>  <b>Antibody Titer Date:</b> _____ <b>Result:</b> _____</p>
<p><b>Meningococcal:</b> One dose of the 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> _____ or <b>Attach 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)**