NEW ENGLAND LAW BOSTON

IMMUNIZATION FORM

Massachusetts State Law 105 CMR 220.000 REQUIRES full-time graduate students and international students (full or part-time) to prove they have received immunizations of Hepatitis B, MMR, Tdap, Varicella, and Meningococcal.

NAME _____
Last *First* *M.I.*

DATE OF BIRTH _____ LSAC ACCOUNT NUMBER _____

PHONE NUMBER _____ EMAIL _____

ADDRESS _____
Street/PO Box *City* *State* *Zip Code*

SECTIONS BELOW MUST BE COMPLETED BY A PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

Measles, Mumps and Rubella (MMR)

1st dose _____ / _____ / _____
MM *DD* *YYYY*

2nd dose _____ / _____ / _____
MM *DD* *YYYY*

OR

☐ Laboratory evidence of immunity (results attached)

Hepatitis B

1st dose _____ / _____ / _____
MM *DD* *YYYY*

2nd dose _____ / _____ / _____
MM *DD* *YYYY*

3rd dose _____ / _____ / _____
MM *DD* *YYYY*

OR

☐ Laboratory evidence of immunity (results attached)

Varicella

1st dose _____ / _____ / _____
MM *DD* *YYYY*

2nd dose _____ / _____ / _____
MM *DD* *YYYY*

OR

☐ History of chickenpox (date of infection:_____)

☐ Laboratory evidence of immunity (results attached)

Tdap (Tetanus/Diphtheria/Acellular Pertussis) (*within the last ten years*) _____ / _____ / _____
MM *DD* *YYYY*

Meningococcal (MenACWY) (only required if 21 years of age or younger) _____ / _____ / _____
MM *DD* *YYYY*

- *Must have been received on or after 16th birthday.*
- *Meningococcal B does not meet this requirement.*

OR

☐ Student is waiving MenACWY vaccine (student must submit signed *MDPH Meningococcal Information and Waiver Form*)

I certify that the above information is a true and accurate statement of the dates on which this student received the above listed immunizations.

_____ _____
Physician/Health Care Provider Name (Please Print) *Physician/Health Care Provider Phone Number*

_____
Name of Clinic

_____ _____
Physician/Health Care Provider Signature *Date Signed*