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**

Program(s): _____ **Email Address:** _____ **Tufts University I.D. Number:** _____

REQUIRED IMMUNIZATIONS:	**TO BE COMPLETED BY HEALTHCARE PROFESSIONAL**
Tetanus Diphtheria Acellular Pertussis (Tdap): 1 dose of the adult Tdap vaccine is required, in lieu of Td booster. The Tdap vaccine was licensed in 2005. ***If Tdap dose is 10 years or older a Td booster is required.***	**Tdap Vaccine Date:** _____ If current Td booster is less than 2 years old, wait to receive Tdap vaccine. **Td vaccine Date:** _____
Measles, Mumps and Rubella (MMR): two doses of MMR vaccine or positive antibody titers for measles, mumps and rubella. ***For antibody titers laboratory reports must be attached.*** *If antibody titer is negative, provide documentation of previous series (if available), negative titer lab report, along with documentation of first dose of new series.*	**MMR #1 Date:** _____ **MMR #2 Date**: _____ **OR** **Measles Antibody Titer Date:** _____ ☐ ***Attach Report*** **Mumps Antibody Titer Date:** _____ ☐ ***Attach Report*** **Rubella Antibody Titer Date:** _____ ☐ ***Attach Report***
Annual TB Testing: **Tuberculosis Skin Test OR QuantiFERON Gold Testing:** Required within 1 year prior to start date and required annually thereafter *(for those with positive test results see positive TB section of form)*	**TB Skin Test Read Date :**_____ **Induration:**_____ **Result:**_____ *Please sign and date form after test has been read mm/dd/yyyy* **OR** **QuantiFERON-TB Gold Test Date:** _____ ☐ ***Attach Report*** *If TB test is positive, a Chest X-ray is required*
Positive TB Test Result: Chest X-ray report required from within 1 year prior to start date **AND** documentation of past positive test ***(for chest x-ray report is required).*** Once matriculated, additional screening of a QuantiFERON test is required annually for students with tuberculin positive status. If documentation of positive TB test is unavailable, physician verification of positive tuberculin status is required. History of BCG vaccine is not acceptable as proof of positive tuberculin status. BCG recipients must provide documentation of a tuberculosis test.	**Chest X-ray Date:** _____ **Result:** _____ ☐ ***Attach Report*** *Documentation of positive TB test required* **BCG Vaccine Date:** _____ **INH Treatment Dates:** _____ to _____
Varicella (Chickenpox): Year of disease, positive antibody titer, or 2 doses of varicella vaccine. ***If submitting antibody titer, must attach laboratory report with titer date and result.***	**Year of Disease:** _____ **OR** **Antibody titer Date**: _____ ☐ ***Attach Report*** **OR** **#1 Date:** _____ **#2 Date:** _____
Hepatitis B: 3 doses of hepatitis B vaccine or positive antibody titer. Testing for immunity, 2 to 6 months after vaccination is recommended.	**#1 Date:** _____ **#2 Date:** _____ **#3 Date:** _____ **OR** **Antibody Titer Date:** _____ ☐ ***Attach Report*** **Booster Dose Date**: _____ *If needed*
Influenza: The 2021-22 Seasonal Influenza vaccine is required for all students. (The 2021-22 vaccine will be available in August 2021)	**Vaccine Date:** _____
COVID-19: Proof of vaccination required.	☐ ***Attach Dose Documentation***
Recommended (except for students 21 years of age and younger): Documentation of a dose of **MenACWY vaccine** received on or after 16th birthday. **Students 21 years of age and younger:** dose on or after 16th birthday or signed State Waiver Form.	**Vaccine Date:** _____
Recommended: Polio: proof of vaccination may be required in the future.	**Vaccine Date(s):** _____

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: _____ Date: _____
Health Care Professional

Provider Name and Title (Please Print): _____

Provider Address: _____ Phone: _____

Please email immunization form and supporting documentation as a black and white .pdf attachment to: Lucia.Fenney@tufts.edu **or fax it to 617-636-2708**
200 Harrison Avenue, Posner Hall 4th Floor, Boston, MA 02111 – Tel: 617-636-2712 https://medicine.tufts.edu/administration/SAHA/immunizations
PLEASE RETAIN COPY OF PAPERWORK FOR YOUR RECORDS