



School of Dental 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): _____ Email Address: _____ Tufts University I.D. Number: _____

REQUIRED IMMUNIZATIONS:

TO BE COMPLETED BY HEALTHCARE PROFESSIONAL

<p>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. <i>If Tdap dose is 10 years or older a Td booster is required.</i></p>	<p>Tdap Vaccine Date: _____</p> <p>If current Td booster is less than 2 years old, wait to receive Tdap vaccine. Td vaccine Date: _____</p>
<p>Measles, Mumps and Rubella (MMR): two doses of MMR vaccine or positive antibody titers for measles, mumps and rubella.</p> <p><i>For antibody titers laboratory reports must be attached.</i></p> <p><i>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.</i></p>	<p>MMR #1 Date: _____ MMR #2 Date: _____</p> <p style="text-align: center;">OR</p> <p>Measles Antibody Titer Date: _____ <input type="checkbox"/> Attach Report</p> <p>Mumps Antibody Titer Date: _____ <input type="checkbox"/> Attach Report</p> <p>Rubella Antibody Titer Date: _____ <input type="checkbox"/> Attach Report</p>
<p>Annual TB Testing: Tuberculosis Skin Test OR QuantiFERON Gold Testing: Required within 1 year prior to start date and required annually thereafter <i>(for those with positive test results see positive TB section of form)</i></p>	<p>TB Skin Test Read Date : _____ Induration: _____ Result: _____</p> <p style="text-align: center;"><i>Please sign and date form after test has been read mm/dd/yyyy</i></p> <p style="text-align: center;">OR</p> <p>QuantiFERON-TB Gold Test Date: _____ <input type="checkbox"/> Attach Report</p> <p style="text-align: center;"><i>If TB test is positive, a Chest X-ray is required</i></p>
<p>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).</p> <p>If documentation of positive TB test is unavailable, physician verification of positive tuberculin status is required.</p> <p>History of BCG vaccine is not acceptable as proof of positive tuberculin status. BCG recipients must provide documentation of a tuberculosis test.</p>	<p>Chest X-ray Date: _____ Result: _____ <input type="checkbox"/> Attach Report</p> <p style="text-align: center;"><i>Documentation of positive TB test required</i></p> <p>BCG Vaccine Date: _____</p> <p>INH Treatment Dates: _____ to _____</p>
<p>Varicella (Chickenpox): Year of disease, positive antibody titer, or 2 doses of varicella vaccine.</p> <p><i>If submitting antibody titer, must attach laboratory report with titer date and result.</i></p>	<p>Year of Disease: _____</p> <p style="text-align: center;">OR</p> <p>Antibody titer Date: _____ <input type="checkbox"/> Attach Report</p> <p style="text-align: center;">OR</p> <p>#1 Date: _____ #2 Date: _____</p>
<p>Hepatitis B: <u>Positive antibody titer required.</u></p> <p>Dates of immunization should be recorded, but will not substitute for antibody titer.</p> <p>Must attach laboratory report with antibody titer date and result.</p> <p><i>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.</i></p>	<p>Antibody Titer Date: _____ <input type="checkbox"/> Attach Report</p> <p>#1 Date: _____ #2 Date: _____ #3 Date: _____</p> <p>Booster Dose Date: _____ <i>(If needed)</i></p>
<p>Meningococcal: 1 dose of Quadrivalent (Menactra or Menevo) vaccine within 5 years prior to start date OR a signed State Waiver Form for all students. <i>(State Waiver Form available on forms page at: https://medicine.tufts.edu/administration/SAHA/immunizations)</i></p>	<p>Vaccine Date: _____ or <input type="checkbox"/> Attach signed State Waiver Form</p>
<p>Influenza: The School of Dental Medicine requires all students to submit documentation of the 2019-20 Annual Seasonal Influenza vaccine or a signed Declination Form. <i>(The 2019-20 vaccine will be available in August 2019. Declination Form will be emailed by the Dental School in the Fall of 2019.)</i></p>	<p>Vaccine Date: _____</p>
<p>Recommended: Polio: proof of vaccination may be required in the future.</p>	<p>Vaccine Date(s): _____</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

Provider Name and Title (Please Print): _____ Date: _____

Provider Address: _____ Phone: _____

Please fax or mail immunization documentation to: Fax: 617-636-2708 – Phone: 617-636-2712 or email to Lucia.Fenney@tufts.edu
 200 Harrison Avenue, Posner Hall 4th Floor, Boston, MA 02111 - <https://medicine.tufts.edu/administration/SAHA/immunizations>