



# School of 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: \_\_\_\_\_

**Please Note: Students going on rotations during 4<sup>th</sup> year may need to meet additional immunization requirements.**

**REQUIRED IMMUNIZATIONS:**

**TO BE COMPLETED BY HEALTHCARE PROFESSIONAL**

|  |   |
|--|---|
| <p><b>Tetanus Diphtheria Acellular Pertussis (Tdap):</b> 1 dose of the adult Tdap vaccine is required, in lieu of Td booster. The Tdap vaccine was licensed in 2005. <b>If Tdap dose is 10 years or older a Td booster is required.</b></p>  | <p><b>Tdap Vaccine Date:</b> _____</p> <p>If current Td booster is less than 2 years old, wait to receive Tdap vaccine.</p> <p><b>Td vaccine Date:</b> _____</p>  |
| <p><b>Measles, Mumps and Rubella (MMR):</b> <u>positive rubella antibody titer required</u> AND 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><b>Rubella Antibody Titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p style="text-align: center;"><b>AND</b></p> <p><b>MMR #1 Date:</b> _____ <b>MMR #2 Date:</b> _____</p> <p style="text-align: center;"><b>OR</b></p> <p><b>Measles Antibody Titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p><b>Mumps Antibody Titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p><b>Rubella Antibody Titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> |
| <p><b>Annual TB Testing:</b><br/> <b>Tuberculosis Skin Test OR QuantiFERON Gold Testing:</b> Required within 1 year prior to start date and required annually thereafter (for those with positive test results see positive TB section of form)</p>  | <p><b>TB Skin Test Read Date :</b> _____ <b>Induration:</b> _____ <b>Result:</b> _____</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;"><b>OR</b></p> <p><b>QuantiFERON-TB Gold Test Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p style="text-align: center;"><i>If TB test is positive, a Chest X-ray is required</i></p>  |
| <p><b>Positive TB Test Result:</b> Chest X-ray report required from within 1 year prior to start date AND documentation of past positive test (<b>for chest x-ray report is required</b>).</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><b>Chest X-ray Date:</b> _____ <b>Result:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p style="text-align: center;"><i>Documentation of positive TB test required</i></p> <p><b>BCG Vaccine Date:</b> _____</p> <p><b>INH Treatment Dates:</b> _____ to _____</p>   |
| <p><b>Varicella (Chickenpox):</b> 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><b>Antibody titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p style="text-align: center;"><b>OR</b></p> <p><b>#1 Date:</b> _____ <b>#2 Date:</b> _____</p>  |
| <p><b>Hepatitis B:</b> <u>positive quantitative (numeric) antibody titer required</u> AND 3 doses of vaccine.</p> <p><i>Must attach quantitative laboratory report with antibody titer date and result.</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><b>Quantitative Antibody Titer Date:</b> _____ <input type="checkbox"/> <b>Attach Report</b></p> <p style="text-align: center;"><b>Antibody Titer Value:</b> _____</p> <p style="text-align: center;"><b>AND</b></p> <p><b>#1 Date:</b> _____ <b>#2 Date:</b> _____ <b>#3 Date:</b> _____</p> <p><b>Booster Dose Date:</b> _____ <i>If needed</i></p>  |
| <p><b>Meningococcal:</b> 1 dose of <b>Quadrivalent</b> (Menactra or Menevo) vaccine within <b>5 years</b> prior to start date OR a signed State Waiver Form for all students. (State Waiver Form available on forms page at: <a href="https://medicine.tufts.edu/administration/SAHA/immunizations">https://medicine.tufts.edu/administration/SAHA/immunizations</a>)</p>  | <p><b>Vaccine Date:</b> _____ or <input type="checkbox"/> <b>Attach signed State Waiver Form</b></p>  |
| <p><b>Influenza:</b> The School of Medicine requires all students to submit documentation of the 2019-20 Annual Seasonal Influenza vaccine. (<b>The 2019-20 vaccine will be available in August 2019.</b>)</p>   | <p><b>Vaccine Date:</b> _____</p>   |
| <p><b>Recommended:</b><br/> <b>Polio:</b> proof of vaccination may be required in the future.</p>  | <p><b>Vaccine Date(s):</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*

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 4<sup>th</sup> Floor, Boston, MA 02111 - <https://medicine.tufts.edu/administration/SAHA/immunizations>