Sackler School of Graduate Biomedical Sciences 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**
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***
TB Testing: **Tuberculosis Skin Test OR QuantiFERON Gold Testing:** Required within 1 year prior to start date *(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).*** 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*
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. (*State Waiver Form available on forms page at:* https://medicine.tufts.edu/administration/SAHA/immunizations*)*	**Vaccine Date:** _____ **or** ☐ **Attach signed State Waiver Form**
Influenza: The 2019-20 Seasonal Influenza vaccine is required for all students with patient contact, unless medically contraindicated. (The 2019-20 vaccine will be available in August 2019)	**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: _____ **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