

Name: _____
 Last First Middle Date of Birth

Address: _____
 Street Apt. City, State, Zip Code

Program(s): _____ Email Address: _____ Tufts University I.D. Number: _____
DVM, MS, PhD, CBS or Ross

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.</p> <p>Td vaccine Date: _____</p>
<p>Measles, Mumps and Rubella (MMR): 2 doses of MMR or positive antibody titers for measles, mumps and rubella.</p> <p><i>If submitting antibody titer(s), must attach laboratory report(s) with titer date(s) and result(s).</i></p>	<p>MMR #1 Date: _____ MMR #2 Date: _____</p> <p align="center">OR</p> <p>Measles Antibody Titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p> <p>Mumps Antibody Titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p> <p>Rubella Antibody Titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p>
<p>Rabies Vaccination:</p> <p>DVM, CBS, Ross, IDGH and MCM: 3 doses of pre-exposure vaccination or positive antibody titer.</p> <p>If vaccine series, booster dose, or antibody titer is older than 2 years a new antibody titer is required. If titer level is insufficient for immunity, a booster dose is required. <i>Laboratory report must be attached.</i></p> <p>MAPP and PhD: 3 doses of pre-exposure vaccination or positive antibody titer for students who work with animals or live rabies virus.</p>	<p>#1 Date: _____ #2 Date: _____ #3 Date: _____</p> <p>Antibody Titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p> <p><i>If antibody titer result is negative a booster is required</i></p> <p>Booster Dose Date: _____ <i>If needed</i></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: _____ OR</p> <p>Antibody titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p> <p align="center">OR</p> <p>#1 Date: _____ #2 Date: _____</p>
<p>Hepatitis B: 3 doses of hepatitis B vaccine or positive antibody titer. Testing for immunity, 2 to 6 months after vaccination is recommended.</p> <p><i>If submitting antibody titer, must attach laboratory report with titer date and result.</i></p>	<p>#1 Date: _____ #2 Date: _____ #3 Date: _____</p> <p align="center">OR</p> <p>Antibody Titer Date: _____ <input type="checkbox"/> <i>Attach Report</i></p> <p>Booster Dose Date: _____ <i>If needed</i></p>
<p>Meningococcal: 1 dose of Quadrivalent (Menaetra 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: http://medicine.tufts.edu/saha)</p>	<p>Vaccine Date: _____ or <input type="checkbox"/> Attach signed State Waiver Form</p>
<p>Influenza: 2019-20 vaccine recommended for all students. Required for those with human patient contact. The 2019-20 vaccine will be available in Aug 2019.</p>	<p>Vaccine Date: _____</p>
<p>Polio: Documentation of vaccination is recommended. 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: _____