

## IMMUNIZATION RECORD FORM

Students must complete and return within 30 days of registration to:

**Enrollment Services Center  
Bunker Hill Community College  
New Rutherford Avenue  
Boston, MA 02129**

- I. All students are subject to immunization requirements for college entry (105 CMR 220.600):
- Full-time undergraduate and graduate students.
  - Part-time and full-time undergraduate students in a health science program and who may be in contact with patients.
  - Part-time and full-time undergraduate students that are attending while on a student visa, including a student attending or visiting classes or programs as part of a formal visitation or exchange program.
- II. Serologic proof of immunity is acceptable documentation.

### **College Immunization Requirements:**

- 1. Hepatitis B: 3 doses**
- 2. Td (Tetanus/Diphtheria): 1 Td booster in last 10 years**
- 3. Measles: 2 doses**
- 4. Mumps: 1 dose**
- 5. Rubella: 1 dose**

### **Please Print**

Today's Date \_\_\_\_\_ SS# or Student ID# \_\_\_\_\_

Last Name \_\_\_\_\_ First Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Program Major \_\_\_\_\_

Check one of the categories below and submit verification as indicated. Please sign your name at the bottom of the page.

In accordance with this law:

- 1. I am submitting a copy of my school immunization record that includes all the required immunizations or disease history as listed on the back of this form.
- 2. I am submitting an immunity history signed by a physician or registered nurse verifying all my immunizations, titres or disease history as listed on the back of this form.

I am exempt from this requirement because of the reason checked and I understand that should a measles case develop in the College, I may be excluded from the College for up to three months.

- 3. I am a part-time student not enrolled in a health program.
- 4. I am submitting a physician's signed statement that verifies that my physical condition will be endangered by the required immunizations. (Physician must complete the Medical Waiver section on the back of this form.)
- 5. Such immunizations conflict with my religious beliefs.

Student Signature \_\_\_\_\_ Date \_\_\_\_\_

**ALL SECTIONS ARE TO BE COMPLETED BY  
PHYSICIAN OR REGISTERED NURSE FOR STUDENTS**

**MEASLES, MUMPS, RUBELLA** (Complete section A, or B.)

(Complete dates are required. Initial immunization: Live vaccine after 12 months of age).

**A. MMR** (Measles, Mumps, Rubella) VACCINES:

#1 Date \_\_\_/\_\_\_/\_\_\_ and at least one month later #2 Date \_\_\_/\_\_\_/\_\_\_

**OR**

**B. MEASLES** (Rubeola) (a or b)

a. Two doses of live vaccine at least one month apart. Dates #1 \_\_\_/\_\_\_/\_\_\_ #2 \_\_\_/\_\_\_/\_\_\_

**OR**

b. Positive Titre \_\_\_\_\_:\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**MUMPS** (Parotitis) (a or b)

a. Live vaccine Date \_\_\_/\_\_\_/\_\_\_ **OR** b. Positive titre \_\_\_\_\_:\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

**RUBELLA** (German Measles) (a or b)

a. Live vaccine Date \_\_\_/\_\_\_/\_\_\_ **OR** b. Positive titre \_\_\_\_\_:\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

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**C. DIPHTHERIA/TETANUS**

Any combination of three or more doses of DPT, DT or TD, provided the last dose was administered within the last ten years.

Type \_\_\_\_\_ Date of latest dose \_\_\_/\_\_\_/\_\_\_

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**D. HEPATITIS B:** Series of three

1) Date \_\_\_/\_\_\_/\_\_\_ 2) one month later-Date \_\_\_/\_\_\_/\_\_\_ 3) six months later-Date \_\_\_/\_\_\_/\_\_\_

**OR**

Positive titre: \_\_\_\_\_:\_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

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**Medical Waiver**

The above-named student has been examined by me. In my opinion the physical condition of the student is such that his/her health will be endangered by any such immunization.

Physician or Registered Nurse Signature \_\_\_\_\_ RN/MD

Printed name \_\_\_\_\_ Date \_\_\_/\_\_\_/\_\_\_

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**THE ABOVE IMMUNITIES ARE IN COMPLIANCE WITH MASSACHUSETTS LAW**

Signed \_\_\_\_\_ RN/MD Date \_\_\_/\_\_\_/\_\_\_

**NOTE: This original form will become part of the student's permanent record. Please make copies for your future use.**