HOLYOKE COMMUNITY COLLEGE IMMUNIZATION FORM

Please submit this form within 30 days of registration

Major: ____________________ **Student I.D.#:** ________________________

LAST NAME ______ **FIRST NAME** ______ **M.I.** ______ **(Maiden/other name used)** ______

PHONE NUMBER ______ **DATE OF BIRTH** _______/_______/_______ **EMAIL ADDRESS** ______

STREET ADDRESS ______ **CITY/TOWN** ______ **STATE / ZIP** ______

All full-time college students (regardless of age) are required by Mass. State law (Chap. 76, Sect. 15C) to submit complete documentation of their immunization records within 30 days of registration. Please ask your health care provider for a copy of any shot records in your file and submit to us for review. Please make sure the records are signed and stamped. You can retrieve your immunization records from your pediatrician, high school, military, other colleges, etc. If you need assistance, please visit our office so we may help you. Some of the state mandated immunizations may be available at the HCC Health Services Office at a low cost. ~ OR ~ Please complete the top portion of this form and submit it to your health care provider for completion and return it to us. **Antibody titer records are acceptable if the lab reports are included** for us to review.

____ / ____ / ____ **DATE OF FIRST MMR** (please specify if only measles was given)

____ / ____ / ____ **DATE OF SECOND MMR** (Or attach a copy of the positive titer results for measles, mumps, and rubella)

____ / ____ / ____ **DATE OF FIRST HEPATITIS B**

____ / ____ / ____ **DATE OF SECOND HEPATITIS B**

____ / ____ / ____ **DATE OF THIRD HEPATITIS B** (Or attach a copy of the positive titer results for Hepatitis B)

Pertussis-containing vaccine is now required; please note and date the formulation below:

____ / ____ / ____ **Tdap** **DATE OF TETANUS/DIPHTHERIA/PERTUSSIS** (2006 or later)

____ / ____ / ____ **Td** **DATE OF TETANUS/DIPHTHERIA**

____ / ____ / ____ **DATE OF FIRST VARICELLA (CHICKEN POX)**

____ / ____ / ____ **DATE OF SECOND VARICELLA (CHICKEN POX)** (Or attach a copy of the positive titer results for Varicella)

or MD may document history of Varicella disease (please specify date): ______________________________________

PRINT NAME OF VACCINE ADMINISTRATOR ______ **SIGNATURE OF PROVIDER** ______

ADDRESS OF HEALTH CARE FACILITY ______ **PHONE NUMBER** ______ **TODAY'S DATE** ______

Please mail to: **HCC HEALTH SERVICES**
IMMUNIZATION RECORDS
FROST BLDG. ROOM 105
HOLYOKE, MA 01040

Or fax to: **413.552.2121**

AFFIX AGENCY STAMP HERE

Questions? Please call our office at **413.552.2401** if you need assistance. Thank you.

Revised 3/2017