HOLYOKE
COMMUNITY
COLLEGE

IMMUNIZATION FORM

(FORM MUST BE SUBMITTED WITHIN 30 DAYS OF REGISTRATION)

Major: ____________________________ Student I.D.#: _____________________________________

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LAST NAME FIRST NAME M.I. (MAIDEN/OTHER NAME USED)

___________________________ ______/________/_______ ____

CELL/PHONE NUMBER DATE OF BIRTH EMAIL ADDRESS

____

STREET ADDRESS CITY/TOWN STATE / ZIP

…. Student Complete Top Portion & Submit to Health Care Provider for Completion & Return to HCC….

All full-time undergraduate and graduate students under 30 years of age and all full and part-time health science students are required by the Massachusetts State law (Chap. 76, Sect. 15C) to submit proof of immunization records within 30 days of registration.

1. Obtain a copy of your immunization records from your health care provider or from an elementary or secondary school in the commonwealth of Massachusetts.
2. Unable to obtain records: ask your provider to perform an antibody titer testing. **Antibody titer records are acceptable if the lab reports are included** for us to review.
3. Have your health care provider complete and return this form to the address below or by fax.
4. Records must be signed and stamped by your health care provider.

__ __ / __ __ / __ __ DATE of MMR#1 (please specify if only measles was given)

__ __ / __ __ / __ __ DATE of MMR#2 (Or attach copies of the positive titer lab reports)

__ __ / __ __ / __ __ DATE of HEPATITIS B#1

__ __ / __ __ / __ __ DATE of HEPATITIS B#2

__ __ / __ __ / __ __ DATE of HEPATITIS B#3 (Or attach a copy of the positive HB surface antibody titer report)

One dose of adult Pertussis-containing vaccine is required

__ __ / __ __ / __ __ DATE of seasonal INFLUENZA vaccine for the current flu season (must be received annually)

__ __ / __ __ / __ __ Tdap - DATE of TETANUS/DIPHTHERIA/PERTUSSIS (within 10 years of last Tdap)

__ __ / __ __ / __ __ Td- DATE of TETANUS/DIPHTHERIA (within 10 years of last Tdap)

__ __ / __ __ / __ __ DATE of VARICELLA#1 (CHICKEN POX)

__ __ / __ __ / __ __ DATE of VARICELLA#2 (Or attach a copy of the positive titer lab report) or

__ __ / __ __ / __ __ DATE of documented history of VARICELLA DISEASE

__ __ / __ __ / __ __ DATE of MenACWY vaccine (required for all full-time students 21 years of age or younger)

______________________________________ ______________________________________

PRINT NAME OF VACCINE ADMINISTRATOR SIGNATURE (PCP, PA, NP, or DESIGNEE)

______________________________________ _________________ _______________

ADDRESS OF HEALTH CARE FACILITY PHONE NUMBER TODAY'S DATE

Please mail to: HCC Student Records & Registrar's Office, Frost 221, Holyoke, MA 01040; Fax: (413) 552-2555; or email: *immunizations@hcc.edu*

Revised 9/2020