MASSART
MASSACHUSETTS COLLEGE
OF **ART AND DESIGN**

Immunization Record Form

Massachusetts college immunization law requires each college to have on fi le a complete record of immunizations for **all full-time undergraduate and graduate students**. As such, students in these programs must provide complete documentation to the Counseling and Wellness Center.

Incoming students must submit the MassArt Immunization Record Form, completed and signed by a physician, no later than June 30 (December 15 for the Spring semester). Incomplete forms will not be accepted. **Students who have not submitted this completed form will not be allowed on campus.** They will not be allowed to move into on-campus housing, swipe into on-campus buildings, or attend classes.

Student Information:

Name: _____ _____ _____ **Date of Birth:** ____ /____ /____
Last First M.I.

Email: _____ **Phone:** _____

Required for all full-time undergraduate and graduate students:

Hepatitis B
- ☐ 3 doses required
- ☐ or Hepatitis B serology proving immunity (please attach)

Dose 1: ____ /____ / ____
Dose 2: ____ /____ /____
Dose 3: ____ /____ /____

Measles, Mumps, Rubella (MMR)
- ☐ 2 doses required
- ☐ or measles, mumps, rubella serology proving immunity (please attach)

Dose 1: ____ /____ /____
Dose 2: ____ /____ /____

TDap
- ☐ 1 dose required within the last 10 years

Dose: ____ /____ /____

Varicella
- ☐ 2 doses required
- ☐ or varicella serology proving immunity (please attach)
- ☐ or documented history of varicella (Date: ___ /___ /___)
- ☐ or birth before 1980 in the United States

Dose 1: ____ /____ /____
Dose 2: ____ /____ /____

Required for all students, 21 years and younger, administered on or after their 16th birthday, regardless of housing status

Meningococcal
- ☐ 1 dose of MenACWY (formerly MCV4) required within the last 5 years (2 doses if dose 1 was given before age of 16)

Dose 1: ____ /____ /____
(Dose 2: ____ /____ /____)

Required for international students only:

Tuberculosis
- ☐ PPD (Mantoux) test given within the last year
- ☐ Chest x-ray if TB test is positive (please attach)

Test Date: ____ /____ /____
Result: ☐ Negative ☐ Positive

I attest that the above information is accurate and complete.

_____
Signature of Physician

_____
Name of Physician (Print)

Phone Number of Physician: _____

Address of Physician: _____
Street Address

_____ _____
City State

_____
Zip Code