Name_____Class_____DOB_____

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LASELL UNIVERSITY IMMUNIZATION RECORD

This form must be completed and signed by a health care provider

REQUIRED VACCINES

Vaccines	*Dates Given*	*MA State Requirements*
Hepatitis B	#1____/____/____ #2____/____/____ #3____/____/____ OR Positive Titer Date ____/____/____	3 doses **OR** positive titer. Minimum of 1 month between doses 1 & 2 Minimum of 4 months between doses 1 &3
Meningococcal	#1_____/_____/_____ ☐ Menactra ☐ Menveo	One dose within past 5 years for all new Freshmen and Transfer students. Must be after 16th birthday.
MMR	#1___/___/___ #2___/___/___ OR Positive Titer Date ___/___/___	*1st dose must be given after 1st birthday. Minimum of 4 weeks between doses.
Tdap/Td	Tdap_____/_____/_____ Td _____/_____/_____	1 Tdap within past 10 years.
Varicella	#1___/___/___ #2___/___/____ OR Positive Titer Date ___/___/____ OR History of Disease: ☐ No ☐ Yes If yes, approx. date ___/___/____	2 doses **OR** positive titer **OR** documented history of disease. Minimum of 4 weeks between doses.

RECOMMENDED/OPTIONAL VACCINES

Vaccines	*Dates Given*	*MA State Requirements*
Hepatitis A	#1____/____/____ #2____/____/____	Recommended if planning travel Interval: 6-12 months between doses 1 &2
Hib	#1____/____/____	Primary Series
HPV	#1____/____/____ #2____/____/____ #3____/____/____	Health care maintenance
Influenza	Most Recent: #1____/____/____	Recommended Annually
Meningococcal B (Bexsero)	#1____/____/____ #2____/____/____	Minimum of 1 month between doses
Pneumococcal	#1_____/_____/_____ ☐ Polysaccharide (PPV) ☐ Conjugate(PCV)	Chronic Health Problems
Covid-19	#1____/____/____ #2____/____/____ #3____/____/____	Primary Series plus booster
Typhoid	☐ Oral ☐ Injectable	Travel
Yellow Fever	#1____/____/____	Travel

SIGNATURE OF HEALTHCARE

PROVIDER_____

PRINT **SIGNATURE** **DATE**

rev. 2/15/23, RA