**Please return completed form to: The Wellness Center** [**welnesscenter@simons-rock.edu**](mailto:%20welnesscenter@simons-rock.edu)

**MASSACHUSETTS REQUIRED IMMUNIZATION HISTORY**

This form must be signed by a physician. The state of

Massachusetts mandates receipt of health records BEFORE campers reside on campus. Unimmunized or under-immunized campers require a letter of explanation of medical or religious exemption.

**FIRST NAME: LAST NAME: DATE OF BIRTH: / /**

**REQUIRED IMMUNIZATIONS:**

**TETANUS/DIPTHERIA/ACELLUALR PERTUSSIS** (Tetanus must be within the last 10 years) **TETANUS/DIPTHERIA/ACELLUALR PERTUSSIS** (Tetanus must be within the last 10 years) Primary series completed / / **Tdap** / /

MM DD YY MM DD YY

**RECOMMENDED IMMUNIZATIONS:**

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|  |
| --- |
| **MEASLES, MUMPS, RUBELLA (MMR) 2 doses required.**  MMR #1 / / (First dose must be after age 12 months)  MM DD YY  MMR #2 / / (Must be at least one month after dose #1)  MM DD YY |
| **MENINGITIS VACCINE**  #1 / / Booster #2 / / 1 dose required. Booster required at 16. |
| **VARICELLA (**2 required)  #1 / / #2 / / (Must be at least one month after dose #1)  **OR** Had the disease / / |
| **HEPATITIS B**  #1 / / #2 / / (Must be at least 1 month after #1)  MM DD YY MM DD YY  #3 / / (Must be at least 2 months after #2 and 4 months after #1) |

**RECOMMENDED IMMUNIZATIONS**

# Human Papillomavirus Vaccine:

#1 / /

#2 / /

#3 / /

# Hep A:

MM DD YY

MM DD YY

MM DD YY

#1 / / #2 / /

MM DD YY MM DD YY

Other:

MM DD YY MM DD YY

**Tuberculosis testing:** A mantoux is **only** required for students determined to be at high risk for tuberculosis. A chest film is required for any **positive** PPD PPD Date / / mm chest X ray Treatment dates

# Physician Name Phone # Fax # Address Physician’s Signature Date