Friedman School of Nutrition Science and Policy
Non-Degree/Special Student Immunization Form
Boston Health Sciences Campus ~ Student Advisory & Health Administration Office

Name: _____ _____
Last **First** **Middle** **Date of Birth**

Address: _____
Street **Apt.** **City, State, Zip Code**

Program(s): _____ **Class:** _____ **Tufts University I.D. Number:** _____
MS, PhD

REQUIRED IMMUNIZATIONS:	**TO BE COMPLETED BY HEALTHCARE PROFESSIONAL**
Tetanus Diphtheria Acellular Pertussis (Tdap): 1 dose of the onetime adult Tdap vaccine is required, in lieu of Td booster. The Tdap vaccine was licensed in 2005.	**Tdap Vaccine Date:** _____ If current Td booster is less than 2 years old, wait to receive Tdap vaccine. **Record Td vaccine Date:** _____
Measles, Mumps and Rubella (MMR): 2 doses of MMR vaccine or positive antibody titers for measles, mumps and rubella. ***If submitting antibody titer(s), must attach laboratory report(s) with titer date(s) and result(s).***	**MMR #1 Date:** _____ **MMR #2 Date**: _____ **OR** **Measles Antibody Titer Date:** _____ **Result:** _____ **Mumps Antibody Titer Date:** _____ **Result:** _____ **Rubella Antibody Titer Date:** _____ **Result:** _____
Tuberculosis Skin Test or QuantiFERON Gold Test: Required within 1 year prior to start date and required annually thereafter. If tuberculin positive, a chest X-ray or QuantiFERON-TB Gold Test is required within 1 year prior to start date. List history of BCG vaccine and/or INH treatment. If history of being tuberculin positive, documentation of past positive test is required. If documentation of past positive Tuberculosis Skin Test is unavailable, physician verification of being tuberculin positive is required. A history of BCG vaccine is not acceptable as proof of being tuberculin positive. BCG recipients must provide documentation of a tuberculosis test.	**TB Skin Test Date:**_____ **Induration:**_____ **Result:**_____ **OR** **QuantiFERON-TB Gold Test Date:** _____ **Result:**_____ *(Laboratory report required)* *If QuantiFERON-TB Gold Test is positive, a Chest X-ray is required.* *If tuberculin positive, a Chest X-ray or QuantiFERON- TB Gold Test is required within 1 year of start date***.** **Chest X-ray Date:** _____ **Result:** _____ *(Report Required)* **BCG Vaccine Date:** _____ **INH Treatment Dates:** _____ to _____
Varicella (Chickenpox): Year of disease, positive antibody titer, or 2 doses of varicella vaccine. ***If submitting antibody titer, must attach laboratory report with titer date and result.***	**Year of Disease:** _____ **OR** **Antibody titer Date**: _____ **Result:** _____ *(Laboratory report required)* **OR** **#1 Date:** _____ **#2 Date:** _____
Hepatitis B: 3 doses of hepatitis B vaccine or positive antibody titer. Testing for immunity, 2 to 6 months after vaccination is recommended. ***If submitting antibody titer, must attach laboratory report with titer dates and result.***	**#1 Date:** _____ **#2 Date:** _____ **#3 Date:** _____ **Booster Dose Date**: _____ *If needed* **OR** **Antibody Titer Date:** _____ **Result:**_____ *(Laboratory report required)*
Meningococcal: 1 dose of vaccine within 5 years prior to start date or a signed State Waiver Form for all students. (*State Waiver Form available on forms page at: http://medicine.tufts.edu/saha*)	**Vaccine Date:** _____ **or Attach signed State Waiver Form**
Influenza: The 2016-17 Seasonal Influenza vaccine is required for all students with patient contact, unless medically contraindicated. (The 2016-17 vaccine will be available in August 2016)	**Vaccine Date:** _____
Polio: Documentation of vaccination is recommended. Proof of vaccination may be required in the future.	**Vaccine Date(s):** _____

State requirements under 105 CMR 220.660 shall not apply where: (1) the student provides written documentation that he or she meets the standards for medical or religious exemption set forth in M.G.L.c.76, 15C.

Signature: _____ **OR** ***Attach other immunization documentation***
Health Care Professional

Provider Name (Please Print): _____ Date: _____

Provider Address: _____ Phone: _____

Please fax or mail immunization documentation to: Fax: 617-636-2708 – Phone: 617-636-2712 or email to Lucia.Fenney@tufts.edu
200 Harrison Avenue, Posner Hall 4th Floor, Boston, MA 02111 - http://medicine.tufts.edu/saha