Tufts UNIVERSITY

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**

Email Address:____**Tufts University I.D. Number:** ____________________

REQUIRED IMMUNIZATIONS:	**TO BE COMPLETED BY HEALTHCARE PROFESSIONAL**
Tetanus Diphtheria Acellular Pertussis (Tdap): 1 dose of the adult Tdap vaccine is required, in lieu of Td booster. The Tdap vaccine was licensed in 2005. ***If Tdap dose is 10 years or older a Td booster is required.***	**Tdap Vaccine Date:** _____________ If current Td booster is less than 2 years old, wait to receive Tdap vaccine. **Td vaccine Date:** _______________
Measles, Mumps and Rubella (MMR): 2 doses of MMR 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:** _______________ ☐ ***Attach Report*** **Mumps Antibody Titer Date:** ________________ ☐ ***Attach Report*** **Rubella Antibody Titer Date:** ________________ ☐ ***Attach Report***
Positive TB Test Result: Chest X-ray report required from within 1 year prior to start date **AND** documentation of past positive test ***(for chest x-ray report is required).*** Once matriculated, additional screening of a QuantiFERON test is required annually for students with tuberculin positive status. If documentation of positive TB test is unavailable, physician verification of positive tuberculin status is required. History of BCG vaccine is not acceptable as proof of positive tuberculin status. BCG recipients must provide documentation of a tuberculosis test.	**TB Skin Test Read Date :**_______ **Induration:**_____ **Result:**________ **OR** **QuantiFERON-TB Gold Test Date:** _______________ ☐ ***Attach Report*** *If QuantiFERON-TB Gold Test is positive, a Chest X-ray is required* **Chest X-ray Date:** _______________ **Result:** _______ ☐ ***Attach Report*** *Documentation of positive TB test 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**: ______________ ☐ ***Attach Report*** **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.	**#1 Date:** __________ **#2 Date:** __________ **#3 Date:** ____________ **OR** **Antibody Titer Date:** ______________ ☐ ***Attach Report*** **Booster Dose Date**: _____________________ *If needed*
Recommended (except for students 21 years of age and younger): Documentation of a dose of **MenACWY vaccine** received on or after 16th birthday. **Students 21 years of age and younger:** dose on or after 16th birthday or signed State Waiver Form.	**Vaccine Date:** ________________ **or** ☐ **Attach signed State Waiver Form**
Influenza: The Seasonal Influenza vaccine is required for all students with patient contact, unless medically contraindicated.	**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: ____ Date: ______________________________
Health Care Professional

Provider Name and Title (Please Print): ____

Provider Address: ____ Phone: __________________________

Please fax, mail or email immunization documentation: Fax: 617-636-2708 – Email: Lucia.Fenney@tufts.edu
200 Harrison Avenue, Posner Hall 4th Floor, Boston, MA 02111 – Tel: 617-636-2712 https://medicine.tufts.edu/administration/SAHA/immunizations