



**Office of Student Affairs**  
 500 Rutherford Avenue  
 Boston, MA 02129  
 Phone: 617.873.0470  
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# Proof of Immunizations - Massachusetts

In compliance with the Dept. of Public Health, all new and returning students at Cambridge College locations in Massachusetts **MUST** complete this form before beginning classes.

**Make an appointment with your physician to get all the vaccinations and/or serology tests listed on this form. Please complete and sign this form at that time.**

**Student and physician/nurse must SIGN below.**

## Student Information

Last name \_\_\_\_\_ First name \_\_\_\_\_ Middle name \_\_\_\_\_

Current Residence:  
 Address \_\_\_\_\_ Apt \_\_\_\_\_ Date of birth: (MM/DD/YY) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Academic program/major \_\_\_\_\_

Phone  home  cell \_\_\_\_\_ School \_\_\_\_\_

Work Phone/ext. \_\_\_\_\_  I am a **full-time** student: Undergraduate: taking 12 credits or more per term.  
 Graduate: taking 8 credits or more per term.

E-mail \_\_\_\_\_  I am a **part-time** student, taking fewer credits per term.

## Student signature \_\_\_\_\_

Date (MM/DD/YY) \_\_\_\_\_

## Exemption

The only circumstances in which you may be exempt from the Massachusetts College Immunization Law are:

- Birth before 1956
- Your physician, who has personally examined you, is of the opinion that your health would be endangered by the required immunizations (explain below or on back of form):
- Conflict with religious beliefs (written statement required; explain below or on back of form).

**Please make an appointment with your physician as soon as possible** to obtain all the vaccinations and/or serology tests listed on this form. Your physician's office needs to fill in the information, sign below, and give you a copy of your immunization history.

**Student and physician/nurse must SIGN** this form.

## Immunizations Required

- TWO MMR (Measles, Mumps, Rubella) vaccines**
  - 1. No earlier than one year after birth (MM/YY) \_\_\_\_\_
  - 2. At least one month after the first (MM/YY) \_\_\_\_\_
- OR serology tests (titers) that demonstrate immunity.
- OR birth before 1957 in the U.S.
- ONE Tdap (tetanus, diphtheria, pertussis) booster**
  - OR Td (tetanus, diphtheria) booster given within the past five years)
- THREE Hepatitis B vaccines**
  - OR serology test (titer) that demonstrates immunity
  - OR two-dose adolescent series
- TWO varicella (chicken pox) vaccines**
  - OR history of varicella verified by your health care provider
  - OR varicella titer that demonstrates immunity
  - OR birth before 1980 in the U.S.

(Please note: Having had a disease is not proof of immunity.)

## Official Signatures

Physician/Nurse name  
 PLEASE PRINT \_\_\_\_\_

Phone \_\_\_\_\_

Board of Registration in Medicine number \_\_\_\_\_

Medical practice name \_\_\_\_\_

Address \_\_\_\_\_

**Physician/Nurse signature** \_\_\_\_\_

Date (MM-DD-YY) \_\_\_\_\_

**Please complete, sign, and return to:**



**Cambridge College**  
 Dean of Student Affairs  
 500 Rutherford Avenue  
 Boston, MA 02129

**Or scan and email to:**  
 studentaffairs@cambridgecollege.edu