Health Services
healthservices@baypath.edu

Proof of Immunizations-Massachusetts

In compliance with the Department 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. Every dose and date of each immunization listed on this form are REQUIRED.
Student and physician/nurse **must SIGN** below.

Student ID#:

Academic program: ___________________________________School: ____________________

Last name: ____ First name: ____________________________ Middle name: __________________

Current address: ____ Apt. ___________

City: ____ State: __________________ Zip code: _______________________

Phone: __________________________________ Email: ____

Date of Birth: _________________________ (MM/DD/YYYY)

Student signature: ___________________________
Date (mm/dd/yyyy): __________________________

I am a full-time student:
□ Undergraduate taking 12 credits or more per academic semester; □ Graduate taking 8 credits or more per academic semester;
□ I am a part-time student, taking fewer credits per academic semester;

Exemptions:

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

□ Birth before 1956

□ Your physician, who had previously examined you, is of the opinion that your health would be endangered by the required immunizations (you must submit a letter from your doctor)

□ Conflict with religious beliefs (written statement required)

Immunizations required (provide a date for each dose of every vaccination below:

TWO MMR (Measles, Mumps, Rubella) vaccines:
MMR dose 1: _____________ MMR dose 2: ___________________
□ OR serology test date: ________________________________
□ OR birth before 1957 in the US

ONE Tdap (tetanus, diphtheria, pertussis) booster:
□ Tdap date: _______________ □ Or TD date: _____________________

THREE Hepatitis B vaccines (Adolescent series 2 doses):
Dose 1: ____________ Dose 2: _____________ Dose 3: _______________
□ OR serology test (titer) date: _________________
□ Mark here if adolescent series

TWO Varicella (Chicken Pox) vaccines:
Dose 1: ___________________ Dose 2: ______________________
□ OR Chicken Pox disease date: _____________________________
□ OR Varicella titer date: __________________________________
□ OR birth before 1980 in the US

Official signatures

Physician/Nurse name ____

Board of Registration in medicine number: __________________________

Medical practice name: ____

Address: ____

Physician/Nurse signature: ____

Date (mm/dd/yyyy): _________________

Please complete, sign and return to:

E-mail to healthservices@baypath.edu, write "Immunizations" in the subject line.

Mail:
Bay Path University
Health Services
588 Longmeadow Street
Longmeadow, MA 01106