NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

Health Services at Wellesley College provided by Newton-Wellesley Collegiate Health

NEW STUDENT IMMUNIZATION RECORD

To be completed by all students and signed by clinician

Student Name: _____

DOB (mm/dd/yy)_____ Anticipated Graduation Date:_____

REQUIRED VACCINATIONS

**Copies of serologic titer results required (attach)*

REQUIRED VACCINATIONS	DATE (mm/dd/yy)	MA state requirements	For office use only
Measles, Mumps, Rubella (MMR) **OR**	Dose 1 _____ Dose 2 _____	**2 doses or positive titers** First dose on or after 1st birthday Second dose at least 4 weeks after first	
Serologic Titers Measles	☐ Immune ☐ Not Immune Date_____		
Mumps	☐ Immune ☐ Not Immune Date_____		
Rubella	☐ Immune ☐ Not Immune Date_____		

Continued on next page

NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

REQUIRED VACCINATIONS	DATE (mm/dd/yy)	MA state requirements	For office use only
Varicella **OR** **Serologic Titers**	Dose 1 _____ Dose 2 _____ □ Immune □ Not Immune Date_____	**2 doses or positive titer** First dose on or after 1st birthday Second dose at least 4 weeks after first *History of disease not accepted*	
Hepatitis B **OR** **Serologic Titers**	Dose 1 _____ Dose 2 _____ Dose 3 _____ □ Immune □ Not Immune Date _____	**3 doses or positive titer** Min 4 wk between dose 1 and 2 Min 8 wk between dose 2 and 3 Min 16 wk between dose 1 and 2	
Tdap (Tetanus, Diptheria, Pertussis)	Dose _____	**Within 10 years of date of enrollment** If Tdap given >10 years from date of enrollment, Td or Tdap can be given for booster	

Continued on next page

NEWTON-WELLESLEY HOSPITAL
2014 Washington Street
Newton, Massachusetts 02462

PATIENT IDENTIFICATION AREA

REQUIRED VACCINATIONS	DATE (mm/dd/yy)	MA state requirements	For office use only
Meningococcal Quadrivalent (MenACWY) Vaccine (Menactra/Menveo/Nimenrix) OR **Signed Meningococcal Vaccine waiver (found on HS website)**	Dose _____ ☐ Declined (Waiver Signed)	**1 dose** MenACWY required for full time students 21 years old or younger Must have been given on or after 16th birthday	

ADDITIONAL IMMUNIZATIONS (not required)

	Date	Date	Date
Hepatitis A			
HPV (Gardasil)			
Rabies			
Typhoid (injectable)			
Typhoid (oral)			
Japanese Encephalitis			
Yellow fever			
Meningococcal Group B MenB-4C(Bexsero) Or MenB- FHbp (Trumenba)			

Provider's Name _____(M.D./P.A./N.P.)

Provider's Signature _____ Date _____ Time _____

Provider's address, Phone Number, Fax Number: