# Immunization Record

**Immunizations Required by MA law for Wellesley College Entry**  
**USE THIS FORM ONLY IF ELECTRONIC COPY OF COMPLETE & SIGNED IMMUNIZATION RECORD FROM CLINICIAN IS UNAVAILABLE**

## Tetanus-Diptheria-Pertussis
- Completed Primary/Childhood Series required
- Date of final dose of DTP/Dtap (mm/dd/yy): ________________
- **AND**
  - Tdap booster required after 6/2005
  - Date: ____________
  - (if no Tdap, Td booster within 5 years is acceptable)
  - Td Date: ____________

## Measles, Mumps, Rubella (MMR)
- Combined MMR- 2 doses required:
  - Dose 1 given on or after 12 months of age
  - Date (mm/dd/yy): ________________
  - Dose 2 given at least 4 weeks after first dose
  - Date: ________________
  - **OR**
  - Serologic Titters (MUST provide copy of lab report)
    - Measles
      - Immune
      - Not Immune
      - Date: ________________
    - Mumps
      - Immune
      - Not Immune
      - Date: ________________
    - Rubella
      - Immune
      - Not Immune
      - Date: ________________

## Varicella - 2 doses required
- Dose 1 required on or after 12 months of age
  - Date (mm/dd/yy): ________________
- Dose 2 must be given at least 4 weeks after first dose
  - Date: ________________
  - Recommend a minimum of 3 months between doses if 1-12 years old, and a minimum of 4 weeks between doses if 13 or older
  - **OR**
  - Serologic Titters (MUST provide copy of lab report)
    - Immune
    - Not Immune
    - Date: ________________
  - **OR**
  - Reliable history of Chickenpox disease (Serologic titers preferred)
  - Date (month/year): ________________

## Hepatitis B
- Full 3 dose series required for all students
  - Hep B Dose 1 Date: ________________
  - Specify if 2 adult dose alternate series given
  - Hep B Dose 2 Date: ________________
  - Hep B Dose 3 Date: ________________
  - **OR**
  - Serologic Titters for Hepatitis B Surface Antibody (MUST provide copy of lab report)
    - Hepatitis B
      - Immune
      - Not Immune
      - Date: ________________

## Meningococcal Vaccine
- Meningococcal MenACWY Vaccine (Menactra or Menveo)
  - (2 doses recommended if dose 1 given before age 16)
  - Date: ________________
  - **OR**
  - Meningococcal- Polysaccharide (Menomune) (must be within 5 years)
  - Date: ________________
  - **OR**
  - Signed Meningitis vaccine waiver on website
  - Date: ________________

## Other/Not Required

<table>
<thead>
<tr>
<th>Immunization</th>
<th>Date Dose #1</th>
<th>Date Dose #2</th>
<th>Date Dose #3</th>
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</thead>
<tbody>
<tr>
<td>Hepatitis A</td>
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<tr>
<td>HPV (Gardasil)</td>
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<td>Polio</td>
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<td>Rabies</td>
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<tr>
<td>Typhoid (Injectable)</td>
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<tr>
<td>Typhoid (Oral)</td>
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<tr>
<td>Japanese Encephalitis</td>
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<td>Yellow Fever</td>
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<td>MenB-4C(Bexsero)</td>
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<td>MenB-FHbp (Trumenba)</td>
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Clinician's Signature:
(M.D., N.P., P.A.) (not parent clinician)  
DATE

Please print name & address if different from physical examination clinician