Merrimack College Hamel Health and Counseling Center
Immunization Record

Student Name:_________________________ Date of Birth:________________

In accordance with Massachusetts state law, Merrimack College requires all full time students, All International students, and All Health Science majors regardless of credit load, to submit documentation of the following required immunizations or proof of immunity to Hamel Health and Counseling Center.

Required Immunizations	
Hepatitis B - 3 Dose Series ■ 3 doses required **OR** **Hepatitis B - 2 Dose Series (for ages 11-15 yrs. only (1.0cc)** ■ 2 doses required **OR** ■ Hepatitis B Titer (Serology) ■ **Attach lab documentation of immunity**	**3-Dose Series** **Month/Day/Year** Dose 1 ________/ ________/________ Dose 2 (1 month after 1st Dose) ________/________/_________ Dose 3 (4-6 months after 1st Dose) ________/________/_________ **OR** **2-Dose Series (@ ages 11-15)** Dose 1 ________/ ________/ ________ Dose2 (4-6 months after 1st Dose) ________/________/_________ **OR** ❍ **Attach lab documentation of immunity**
Tetanus-Diphtheria and Pertussis (Tdap) ■ 1 dose of adult **Tdap Within the past 10 years**	**Month/Day/ Year** _______/_______/_________
Measles, Mumps, and Rubella (MMR) ■ 2 doses of MMR **OR** ■ Positive Measles, Mumps, and Rubella Titer (Serology) accepted ■ **Attach lab documentation of Positive Titers**	**Month/Day/Year** **2-Dose Series** MMR Dose 1 _______/ ________/ ________ MMR Dose 2 (1 month after 1st Dose) _______/________/_________ **OR** ❍ **Attach lab documentation of Positive Titers**
Meningococcal Meningitis (Menactra or Menveo) Quadravalent REQUIRED for all newly enrolled full-time students 21 years of age and younger administered on or after 16th birthday. ____ **Meningococcal Group B Vaccine (Trumenba 2-3 dose series or Bexsero 2 dose series)** **(OPTIONAL)**	**Month/Day/Year** _______/_______/_______ _______/_______/_______ ____ **Month/Day/Year** ________/_______/_______ ________/_______/_______ ________/_______/_______
Varicella (Chicken Pox) ■ 2 doses of Varicella required **OR** ■ History of disease documented by Health Professional **OR** ■ Positive Varicella Titer (Serology) accepted ■ **Attach lab documentation of Positive Titers**	**Month/Day/Year** **2-Dose Series** Dose 1 ________/ ________/ ________ Dose2 (1 month after 1st Dose) ________/ ________/ ________ **OR** History of Varicella Disease ________/ ________/ ________ **OR** ❍ **Attach lab documentation of Positive Titers**

The only exceptions to obtaining these vaccinations are Religious and/or Medical Exemptions.
For a Medical Exemption, we must receive a letter from a physician stating that there is a medical reason why the student cannot receive each vaccination.
For a Religious Exemption, contact Hamel Health Center to complete the religious exemption form.

In both cases, the student may be excluded from the campus in the event of an outbreak of a communicable disease for which he or she has not been immunized.

Provider Printed Name:_________________________________ Provider Signature:___________________________________

Address and Phone Number: ____

Upload this form once completed by your healthcare provider
OR
Upload a copy obtained from your healthcare provider

Updated 02/13/2018