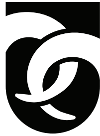

FRAMINGHAM STATE UNIVERSITY

HEALTH CENTER
Foster Hall, Framingham, MA 01701-9101
framingham.medicatconnect.com
P: 508.626.4900

IMMUNIZATIONS RECORD

Student Name: ______________________ Date of Birth (Month/Day/Year): ______________

IMMUNIZATIONS *(to be completed by health care provider only)*

Massachusetts Law Requires Proof of the Following Immunizations:

1. Please have your health care provider complete this form or obtain their record of your completed immunizations
2. Upload the completed immunization record (signed by your health care provider) to the Patient Portal: **framingham.medicatconnect.com**

MMR (Measles, Mumps, Rubella) — **Date**

☐ Dose 1 (on or after first birthday) — #1__________
☐ Dose 2 (at least 28 days after Dose 1) — #2__________
OR
☐ Serology (TITERS) **MUST UPLOAD COPY OF LAB REPORT**

Tdap (Tetanus, Diphtheria, Pertussis) — **Date**

☐ Booster within last ten years (Td not acceptable) — __________

Hepatitis B

☐ Primary 3 dose Series (Engerix-B or Recombivax-HB) #1__________ #2__________ #3__________
OR
☐ 2 doses of Heplisav B (18+ only) #1__________ #2__________
OR
☐ Serology (TITER) **MUST UPLOAD COPY OF LAB REPORT**

Varicella (Chicken Pox) — **Date**

☐ Dose 1 (on or after first birthday) — #1__________
☐ Dose 2 (at least 28 days after Dose 1) — #2__________
OR
☐ Serology (TITER) **MUST UPLOAD COPY OF LAB REPORT**
OR
☐ History of disease (specify date) — __________

Meningococcal Conjugate (ACWY):
(Required for those age 21 and younger, AND for ALL CAMPUS RESIDENTS regardless of age)

Date

☐ Received vaccine (on or after 16th birthday) — __________
OR
☐ Waiver with student hand-written signature **(MUST UPLOAD SIGNED COPY OF WAIVER)**

HEALTH CARE PROVIDER

Name: ______________________ Signature: ______________________ Date: ______________

Office address: ______________________________ Phone: ______________