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: _____