Northeastern University
College *of* Professional Studies

IMMUNIZATION HISTORY FORM

NOTE: Students may not participate in the Summer Pre-College Program until this form has been received.
This form requires a physician's signature.

Summer Pre-College Program
College of Professional Studies
Northeastern University
360 Huntington Avenue, 50 NI
Boston, Massachusetts 02115

STUDENT CONTACT INFORMATION

Please print

Student's Name ______________________________ Gender: ☐ Male ☐ Female

Home Address ______________________ City/State/Zip ______________________

Date of Birth (mm/dd/yy) ______________________ Social Security ______________________

Parent/Guardian Name(s) ______________________________

Parent/Guardian Address (if different from above) ______________________________

Home Phone ______________________ Student Cell ______________________

Parent/Guardian Day Phone ______________________ Evening Phone ______________________

Emergency Contact ______________________ Relationship ______________________

Emergency Day Phone ______________________ Evening Phone ______________________

THE FOLLOWING SECTION MUST BE COMPLETED AND SIGNED BY YOUR MEDICAL PROVIDER.

Medical Provider: Please document immunization dates below. If documentation is unavailable, re-immunization is a pre-matriculation requirement. Registration will be denied if the required immunizations are not documented. A physical examination is NOT required.

☐ Student is exempt from immunization requirements due to a medical contraindication or religious beliefs. A signed statement from a Healthcare Provider or Clergy is required.

[Over for Record of Immunizations]

REQUIRED IMMUNIZATIONS

1. **Tetanus-Diphtheria-Acellular Pertussis (Tdap): Single dose required if it has been two years or more (prior to July 20, 2010) since the last dose of tetanus-diphtheria (Td) vaccine. If Tdap has been received within the past 10 years (after July 20, 2002) another dose is unnecessary.**

   Dose # 1: ____________
   DATE

2. **Two (2) MMR (Measles/Mumps/Rubella)***

   ---1st _______________ **and 2nd** _____________________
   DATE DATE

   or

   Two (2) Measles* 1st _______________________ **and 2nd** _______________________
   DATE DATE

   or

   positive titre _______________________
   DATE

   and

   One (1) Mumps* 1st _______________________ **or positive titre** _______________________
   DATE DATE

   and

   One (1) Rubella* 1st _______________________ **or positive titre** _______________________
   DATE DATE

   *Since 1968, after twelve months of age, thirty days apart if two doses are required.

3. **Hepatitis B (must have at least first dose):**

   Dose #1:___________ Dose 2:___________ Dose #3:___________
   Date Date Date

4. **Polio** – Completed primary series? ☐ YES _____________________ ☐ NO
   DATE

Series of three: the 2nd at least one month after the 1st, the third at least two months after the 2nd and four months after the 1st

5. **Varicella-** had disease OR had vaccine ____________________ ____________________
   DATE #1 REQUIRED DATE #2
   Series of two at least 28 days apart

6. **Other Vaccines:**

   ____

   ____

   ____

Student Name: ____

Name of medical provider (please print) ____

Provider's signature ____

Address ____ City/State/Zip ________________________

Telephone:______________________________ Date:_______________

FAX OR MAIL THIS FORM TO:

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