

Graduate & Lesley Center for the Adult Learner (LCAL)

Certificate of Immunizations 2018–2019

MASSACHUSETTS STATE LAW MANDATES THAT ALL FULL-TIME STUDENTS IN MA PROVIDE PROOF OF IMMUNIZATION.

Your completed form, signed by a physician or nurse (not a parent), must be sent PRIOR to your first semester. Send scanned, faxed or original copies to the: Graduate & LCAL Student Immunizations Office • 29 Everett St., Cambridge, MA 02138 • F: 617.349.8558 • P: 617.349.8543 • ImmunizationsGradStu@lesley.edu

IMPORTANT NOTE: If we do not receive this COMPLETED form within 30 days of the start of full-time classes, a 'hold' may be put on your account which will prohibit you from registering for classes in the future. Be sure to check your LOIS account to determine when any 'holds' put on your account have been removed. Keep a copy of your Certificate of Immunizations for your own records.

Please type or print all information. It is very important that ALL information is complete and legible.

First Name	Middle Name	Last Name		
Street	Apt. No.	City	State	Zip
Home Phone	Cell Phone	Date of Birth	Lesley Student ID#	
Name of Academic Program	Start Date of Program	Lesley Email Account (<i>where immunization communications will be sent</i>)		

Required Immunizations Please have your nurse or physician complete and sign this section

MMR Requirement	Date First Vaccine Given	Date of Second Vaccine Given	OR	Date of Positive Serological Tests (3) (Attach lab results)
MMR				

The MMR Requirement consists of: 2 MMRs (Measles, Mumps and Rubella) given after the 1st birthday, and at least one month apart. If born in USA before 1957, you are considered immune to MMR.

Chicken Pox/Varicella	Dose 1 Date	Dose 2 Date	OR	Date of Healthcare Provider Diagnosed Illness	OR	Date of Positive Serology (Attach lab results)
Varivax						

Varivax: 2 doses required at least a month apart. If born in USA before 1980, you are considered immune to Varicella.

Tetanus Diphtheria Pertussis	Tdap (required) Date	Td (if relevant) Date

One Tdap is required. The date of the last dose given, whether Tdap or Td, should be within the past ten (10) years.

Hepatitis B	Date Given	Vaccine Type	OR	Date of Positive Serology (Attach lab results)
1 st Dose				
2 nd Dose				
3 rd Dose				

The second dose of Hepatitis B must be given no sooner than one (1) month after the first dose. The third dose must be given no sooner than five (5) months after the second dose

Meningococcal	MenACWY (required) Type & Date	Other meningitis vaccine Date and Vaccine Type

All students 21 years of age are REQUIRED to either document that you have had the vaccine after your 16th birthday, or sign the official waiver form stating that you understand the risks and choose not to receive the vaccine.

* Recommended not required

HPV Vaccine	Dose 1 Date	Dose 2 Date	Dose 3 Date

PLEASE COMPLETE REQUIRED TUBERCULOSIS SCREENING QUESTIONNAIRE ON NEXT PAGE.

Physician/Nurse Signature (REQUIRED, Not Parent)	Provider Name (Please Print)	Date	
Office Address	Contact Person	Office Phone Number	Fax

Student Health Service

Mantoux Tuberculin Requirement

STUDENT MUST COMPLETE ALL QUESTIONS

Name _____ Date of birth (month/date/year) _____ Country of birth _____

To the best of your knowledge, have you had close contact with anyone who was sick with tuberculosis? Yes No

To answer the next two questions, please refer to the following list of countries and territories that have high rates of tuberculosis.

Afghanistan	Cambodia	Equatorial Guinea	Iraq	Marshall Islands	Pakistan	Swaziland
Angola	Cape Verde	Eritrea	Kazakhstan	Mauritania	Palau	Syrian Arab Rep.
Armenia	Central African Rep.	Estonia	Kenya	Mauritius	Panama	Tajikistan
Azerbaijan	Chad	Ethiopia	Kiribati	Micronesia	Papua New Guinea	Tanzania, UR
Bahamas	China	Gabon	Korea, DPR	Moldova, Rep.	Paraguay	Thailand
Bahrain	China, Hong Kong SAR	Gambia	Korea, Rep.	Mongolia	Philippines	Togo
Bangladesh	China, Macao SAR	Georgia	Kyrgyzstan	Morocco	Portugal	Tokelau
Belarus	Colombia	Ghana	Lao PDR	Mozambique	Romania	Turkmenistan
Benin	Comoros	Guatemala	Latvia	Myanmar	Russian Federation	Uganda
Bhutan	Congo	Guinea	Lesotho	Namibia	Rwanda	Ukraine
Bolivia	Congo, DR	Guinea-Bissau	Liberia	Nepal	Sao Tome & Principe	Vanuatu
Bosnia & Herzegovina	Cote d'Ivoire	Guyana	Lithuania	New Caledonia	Solomon Islands	Vietnam
Botswana	Croatia	Haiti	Macedonia, TFYR	Nicaragua	Somalia	Yemen
Brazil	Djibouti	Honduras	Madagascar	Niger	South Africa	Zambia
Brunei Darussalam	Dominican Rep.	India	Malawi	Nigeria	Sri Lanka	Zimbabwe
Burkina Faso	Ecuador	Indonesia	Maldives	Niue	Sudan	
Burundi	El Salvador	Iran	Mali	Northern Mariana Islands	Suriname	

Were you born in one of the countries on the list above? Yes No

Have you traveled or lived for more than one month in any of the countries on the list above? Yes No

If you answered Yes to ANY of the questions above, you are required to submit documentation of a Mantoux 5TU PPD test (see below), or a QuantiFERON-TB Gold Assay test result. The test must have been performed within 6 months prior to arrival on campus.

- Multiple-puncture tests are not acceptable (Tine, Heaf, etc.)
- History of BCG vaccination is not a contraindication to TB testing

TESTING DOCUMENTATION FOR A "YES" ANSWER TO ANY OF THE ABOVE QUESTIONS:

Mantoux PPD (tuberculin 5TU) test date _____
(month/day/year)

Clinical Evaluation Normal Abnormal

Results: size of induration _____ mm
(number in millimeters)

(describe)

If a QuantiFERON-TB Gold assay was performed, a copy of the test result must be submitted. If a student had positive tuberculin testing, now or by history, the following are required:

Treatment Yes No

(drug, dose, frequency and dates)

Date of Positive PPD _____

Chest X-ray (required, Attach report, NOT the X-ray)

Normal Abnormal

Healthcare Provider Signature (required)

Date

(describe)

Phone

Fax