BENTLEY UNIVERSITY IMMUNIZATION RECORD REQUIRED
FULL TIME STUDENTS (UG: 12+ CREDITS, GR: 9+ CREDITS) ONLY
TO BE COMPLETED, SIGNED AND DATED IN MONTH/DAY/YEAR FORMAT, BY YOUR HEALTH CARE PROVIDER

Student Name: _____ _____ Date of Birth: ____/____/_____
Last First MI Gender Month Day Year

In accordance with MASSACHUSETTS LAW (College Immunization Law, Chapter 76, Sections 15c and 15d) Bentley University requires documentation of immunization or immunity to varicella, measles, mumps, rubella, tetanus, diphtheria, hepatitis B, and meningitis. Documentation must include the exact dates for all immunizations **or** positive antibody titer **or** provider documented evidence of having had the disease. If antibody titer indicates lack of immunity, vaccines must be administered.

REQUIRED IMMUNIZATIONS

A. **MMR (MEASLES, MUMPS, RUBELLA): 2 doses required (Dose 1 on or after 12 months of age)**

Dose 1 (Immunized, **ON or AFTER**, the first birthday): ____/____/_____
Month Day Year

Dose 2 (Given at least 28 days after Dose 1): ____/____/_____
Month Day Year

OR Documentation of POSITIVE antibody titers (Please attach a copy of results. Must include all 3 titers.):

Measles titer: ____/____/_____ Mumps titer: ____/____/_____ Rubella titer: ____/____/_____
Month Day Year Month Day Year Month Day Year

B. **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap, Boostrix or Adacel): accepted at age ≥ 7, but ideally after age 11. Td or Tdap booster is required if it has been 10 years or more since Tdap**

Tdap Date: ____/____/_____ **If Tdap > 10 yrs prior, need Td:** ____/____/_____ **OR Tdap:** ____/____/_____
Month Day Year Month Day Year Month Day Year

C. **HEPATITIS B VACCINE: 3 doses required of Engerix-B or Recombivax-B, or 2 doses of Heplisav B** (18+ only)

Dose 1: ____/____/_____ **Dose 2**: ____/____/_____ **Dose 3**: ____/____/_____
Month Day Year Month Day Year Month Day Year

Check Here if **Heplisav B (2-dose series)** was given instead of 3-dose series: _____

OR Documentation of POSITIVE antibody titer (Please attach a copy of results): ____/____/_____
Month Day Year

D. **MENINGOCOCCAL ACWY (quadrivalent) VACCINE: for students 21 years and under (REQUIRED TO BE ADMINISTERED AFTER AGE 16)**

Menactra Date: ____/____/_____ **OR** Menveo Date: ____/____/_____
Month Day Year Month Day Year

E. **VARICELLA: 2 doses required (Dose 1 on or after 12 months of age)**

Dose 1 (Immunized, **ON or AFTER**, the first birthday): ____/____/_____
Month Day Year

Dose 2 (Given at least one month after Dose 1): ____/____/_____
Month Day Year

OR Documentation of DISEASE HISTORY verified by health care provider: ____/____/_____
Month Day Year

OR Documentation of POSITIVE antibody titer (Please attach a copy of results): ____/____/_____
Month Day Year

RECOMMENDED IMMUNIZATIONS: FLU & COVID VACCINES ARE SUBJECT TO CHANGE & MAY BE REQUIRED

A. **COVID VACCINE** (Most recent dose/booster)**:** ____/____/_____
B. **HPV VACCINE:** Dose 1: ____/____/_____ Dose 2: ____/____/_____ Dose 3: ___/____/_____
C. **HEPATITIS A:** Dose 1: ____/____/_____ Dose 2: ____/____/_____
D. **MENIGOCCOCAL B VACCINE:** Dose 1: ____/____/_____ Dose 2: ____/____/_____ Dose 3: ___/____/_____
E. **SEASONAL FLU** (Should be administered after July 1 of each year)**:** ____/____/_____

HEALTHCARE PROVIDER INFORMATION AND SIGNATURE

Name (printed): _____ Signature: _____
Address: _____
Telephone: _____ Fax: _____ Date of completion: ____/____/_____

****PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORD****

Once form is completed, submit online via the Bentley Health Portal (bentley.medicatconnect.com) use the Upload tab to submit the completed form. Dates also must be entered using the Immunization tab.