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

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

OR Documentation of POSITIVE antibody titer: (Please attach a copy of results):

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

B. TETANUS, DIPHTHERIA, PERTUSSIS (Tdap, Boostrix or Adacel) around age 11-12 and Td/Tdap booster every 10 years thereafter.

Tdap Date: ____/____/____ **(Adacel or Boostrix) and if needed Td:** ____/____/_____
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

Dose 1: ____/____/_____ **Dose 2 (1 month after 1st dose)**: ____/____/_____
Month Day Year Month Day Year

Dose 3 (6 months after 1st dose preferred or at least 16 weeks after 1st dose and 8 weeks after 2nd dose): ____/____/_____
Month Day Year

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

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

OR Documentation of disease verified by health care provider ____/____/____
Month Day Year

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

F. **COVID VACCINE (WHO Accepted preferred):** Dose 1: ____/____/____ and if needed Dose 2: ____/____/____

RECOMMENDED IMMUNIZATIONS: FLU VACCINE IS SUBJECT TO CHANGE & MAY BE REQUIRED

A. **HPV VACCINE:** Dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ___/____/____
B. **HEPATITIS A:** Dose 1: ____/____/____ Dose 2: ____/____/____
C. **MENIGOCCOCAL B VACCINE:** Dose 1: ____/____/____ Dose 2: ____/____/____ Dose 3: ___/____/____
D. **SEASONAL FLU: Influenza vaccine for 2021-2022 flu season to be administered after July 1, 2021:** ____/____/____

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 Immunizations tab.