**BENTLEY UNIVERSITY IMMUNIZATION RECORD REQUIRED**

**FULL TIME STUDENTS (UG: 12 CREDITS, GR: 9 CREDITS) ONLY**

**TO BE COMPLETED, SIGNED AND DATED, 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 and/or positive antibody titer. If antibody titer indicates lack of immunity, vaccines must be administered.   Immunizations required before moving into housing or beginning classes.

**REQUIRED IMMUNIZATIONS**

1. **MMR (MEASLES, MUMPS, RUBELLA) 2 doses required**

**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

1. **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap, Boostrix or Adacel) at or after age 11 and** **Td (tetanus) booster every 10 years after the Tdap.**

**Tdap Date:** \_\_\_\_/\_\_\_\_/\_\_\_\_ **(Adacel or Boostrix)     and /or     Td:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_

Month    Day    Year                                                                                         Month    Day         Year

1. **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 (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

1. **MENINGOCOCCAL (quadrivalent) VACCINE (ADMINISTERED AFTER AGE 16 AND WITHIN THE LAST 5 YEARS)**

                       Menactra Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_     **OR**    Menveo Date: \_\_\_\_/\_\_\_\_/\_\_\_\_\_

      Month      Day    Year                                          Month      Day    Year

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

 **Dose 1**: \_\_\_\_/\_\_\_\_/\_\_\_\_   **Dose 2 (1 month after 1st dose)**:  \_\_\_\_/\_\_\_\_/\_\_\_\_

                   Month   Day      Year                                                                        Month   Day       Year

**OR Documentation of POSITIVE antibody titer: (Please attach a copy of results)**\_\_\_\_/\_\_\_\_/\_\_\_\_\_

                                           Month    Day       Year

**OR Documentation of** **disease verified by health care provider**\_\_\_\_/\_\_\_\_/\_\_\_\_

                   Month    Day     Year

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**RECOMMENDED IMMUNIZATIONS**

1. **HPV VACCINE:**Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_     Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_     Dose 3: \_\_\_/\_\_\_\_/\_\_\_\_
2. **HEPATITIS A:**Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_      Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_
3. **MENIGOCCOCAL B VACCINE: (Trumenba or Bexsero)**Dose 1: \_\_\_\_/\_\_\_\_/\_\_\_\_     Dose 2: \_\_\_\_/\_\_\_\_/\_\_\_\_     Dose 3: \_\_\_/\_\_\_\_/\_\_\_\_

**HEALTHCARE PROVIDER**

Name (printed): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_     Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tel:(\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_           Date of completion: \_\_\_\_/\_\_\_\_/\_\_\_\_

**\*\*PLEASE KEEP A COPY OF THIS FORM FOR YOUR RECORD\*\***
Once form is completed, use the Document Upload feature in Online Student Health ([https://patientportal.bentley.edu](https://patientportal.bentley.edu/)) to submit the form.