Bunker Hill Community College
imagine the possibilities

ge ID Number _____

IMMUNIZATION RECORD

Return the completed form to:

Student Central
Bunker Hill Community College
250 New Rutherford Avenue, B202
Boston, MA 02129

scan and email to: StudentCentral@bhcc.mass.edu
fax to: 617-228-2371

The following students are subject to immunization requirements for college entry in accordance with Massachusetts General Laws

- All full-time students enrolled in 12 or more credit hours
- All full-time and part-time students enrolled in health professions programs

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Step #1: Complete the following. Please Print.

Today's Date: _____ Student ID #: _____

Last Name: _____ First Name: _____

Date of Birth: _____ Program of Study: _____

Phone no.:_____

Step #2: Check one of the categories below and submit verification as indicated.

In accordance with this law:

☐ I am submitting a copy of my school immunization record that includes all the required immunizations or disease history as listed on the back of this form.

☐ I am submitting an immunity history signed by a physician or registered nurse verifying all my immunizations, titers or disease history as listed on the back of this form.

☐ I am exempt from this requirement because of the reason checked and I understand that should a case of vaccine preventable or communicable disease develop in the College, I may be excluded from the College as described in the Reportable Diseases and Isolation and Quarantine Requirements (105 CMR 300.00).

☐ I am a part-time student not enrolled in a health professions program. (Do not complete Step #4)

☐ I am submitting a physician's signed statement verifying that an immunization is not medically advisable. (Do not complete Step #4)

☐ I am submitting a statement that immunizations conflict with my sincere religious beliefs. (Do not complete Step #4)

Step #3: Please sign your name.

Student Signature: _____ Date: _____

STUDENT SIGNATURE AUTHORIZES RELEASE OF IMMUNIZATION INFORMATION TO BUNKER HILL COMMUNITY COLLEGE

Student College ID Number _____

Step #4: Required Immunization Documentation. **Have all sections completed by a Physician or Registered Nurse.**

MEASLES, MUMPS, RUBELLA (MMR) 2 Doses required, separated by at least one month, with the initial dose given on or after 1st birthday or serologic proof of immunity. Birth before 1957 in the U.S. is also acceptable, except for Health Professions' students.

Dose # 1 – Date: ____/____/____ Dose #2 – Date: ____/_____/_____
OR
*Positive Measles Titer - Date: _____/_____/_____; *Positive Mumps Titer – Date: _____/_____/_____

*Positive Rubella Titer – Date: _____/_____/_____;
OR
Born in the U.S. Before 1957 – Date of Birth: ____/_____/_____

HEPATITIS B Series of three doses or serologic proof of immunity.

Dose #1 - Date: ____/____/____; one month later- Date: ___/___/___; six months later - Date: ___/___/___/
OR
*Positive Titer – Date: _____/_____/_____

VARICELLA *(Chickenpox)* 2 Doses of varicella vaccine, separated by at least one month, or serologic proof of immunity. Health provider reported history of chickenpox disease and birth before 1980 in U.S. are acceptable except for health professions students.
Dose #1 – Date: _____/_____/_____ Dose #2 – Date: _____/_____/_____
OR
*Positive Titer – Date: _____/_____/_____
OR
Reliable History of Chickenpox Disease: Date of Illness - _____/_____/_____
OR
Born in the U.S. before 1980 - Date of Birth: _____/_____/_____

NOTE: *Students with serologic proof of immunity to Measles, Mumps, Rubella, Hepatitis B and/or Varicella, must have a laboratory confirmed result on file.*

TETANUS/DIPHTHERIA/ACELLULAR PERTUSSIS (Tdap) One dose given after 2005

Tdap – Date: ____/_____/_____; Td Booster - Date: _____/_____/_____

MENINGOCOCCAL **For students < 22yrs of age;** one dose of MenACWY (formerly MCV4) between 16th and 21st birthday. Student may decline the MenACWY vaccine after they have read and signed, and submitted with this record the MDPH Meningococcal Information and Waiver Form

Dose #1 – Date: _____/_____/_____ Date of Birth: _____/_____/_____

THE ABOVE IMMUNIZATION DOCUMENTATION IS IN COMPLIANCE WITH MASSACHUSETTS LAW.

Doctor or Nurse Printed Name: _____ Date: _____

Doctor or Nurse Signature: _____

Doctor or Nurse Address: _____

Phone Number: _____ Fax Number: _____

NOTE: This original form will become part of the student's permanent record. Please make copies for your future use.