Cambridge College

Office of Student Affairs
500 Rutherford Avenue
Boston, MA 02129
Phone: 617.873.0470
regina.robinson@cambridgecollege.edu

Proof of Immunizations - Massachusetts

In compliance with the Dept. of Public Health, all new and returning students at Cambridge College locations in Massachusetts MUST complete this form before beginning classes.

Make an appointment with your physician to get all the vaccinations and/or serology tests listed on this form. Please complete and sign this form at that time.

Student and physician/nurse must SIGN below.

Student Information

Last name _____ First name _____ Middle name _____

Current Residence:
Address _____ Apt _____

City _____ State _____ Zip _____

Phone ☐ home ☐ cell _____

Work Phone/ext. _____

E-mail _____

Date of birth: (MM/DD/YY) _____

Academic program/major _____

School _____

☐ I am a *full-time* student: Undergraduate: taking 12 credits or more per term.
Graduate: taking 8 credits or more per term.

☐ I am a *part-time* student, taking fewer credits per term.

Student signature _____

Date (MM/DD/YY) _____

Exemption

The only circumstances in which you may be exempt from the Massachusetts College Immunization Law are:

☐ Birth before 1956

☐ Your physician, who has personally examined you, is of the opinion that your health would be endangered by the required immunizations (explain below or on back of form):

☐ Conflict with religious beliefs (written statement required; explain below or on back of form).

Please make an appointment with your physician as soon as possible to obtain all the vaccinations and/or serology tests listed on this form. Your physician's office needs to fill in the information, sign below, and give you a copy of your immunization history.

Attach your immunization history to this form and submit BOTH to Cambridge College Admissions.

Student and physician/nurse must SIGN this form.

Immunizations Required

☐ **TWO MMR (Measles, Mumps, Rubella) vaccines**
1. No earlier than one year after birth (MM/YY) _____
2. At least one month after the first (MM/YY) _____
☐ OR serology tests (titers) that demonstrate immunity.
☐ OR birth before 1957 in the U.S.

☐ **ONE Tdap (tetanus, diptheria, pertussis) booster**
☐ OR Td (tetanus, diptheria) booster given within the past five years)

☐ **THREE Hepatitis B vaccines**
☐ OR serology test (titer) that demonstrates immunity
☐ OR two-dose adolescent series

☐ **TWO varicella (chicken pox) vaccines**
☐ OR history of varicella verified by your health care provider
☐ OR varicella titer that demonstrates immunity
☐ OR birth before 1980 in the U.S.

(Please note: Having had a disease is not proof of immunity.)

Official Signatures

Physician/Nurse name
PLEASE PRINT _____

Phone _____

Board of Registration in Medicine number _____

Medical practice name _____

Address _____

_____

Physician/Nurse signature _____

Date (MM-DD-YY) _____

Please complete, sign, and return to:

Cambridge College
Dean of Student Affairs
500 Rutherford Avenue
Boston, MA 02129

Or scan and email to:
studentaffairs@cambridgecollege.edu

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