

REQUIRED IMMUNIZATIONS 2023-2024

Action Item! 2 Steps:

1. Login to the UMass Patient Portal at <https://umass.medicatconnect.com> and go to the Upload page to upload this form and all supporting documents (immunization and titer records).
2. Enter dates of vaccinations or titer results into fields on the Patient Portal Immunization page.

Required Vaccines	Dates Given	MA State Requirements
MMR <i>Measles, Mumps and Rubella, combined</i> <p style="text-align: center;">-or-</p> <i>Individual vaccines or positive titers</i> Measles Mumps Rubella	#1 ____ #2 ____ <p style="text-align: center;">-or-</p> #1 ____ #2 ____ Or positive titer – date: ____ #1 ____ #2 ____ Or positive titer – date: ____ #1 ____ #2 ____ Or positive titer – date: ____	Two doses: <ul style="list-style-type: none"> • Minimum of four weeks between doses • First dose given after 1st birthday <p style="text-align: center;">-or-</p> Individual vaccines <p style="text-align: center;">-or-</p> Positive titers (blood tests for immunity)
Tdap <i>Tetanus, Diphtheria, Pertussis</i>	Date: ____	One dose
Meningococcal: MenACWY <i>Meningitis vaccine</i> Menactra®/Menveo®..... <p style="text-align: center;">-or-</p> Menomune®..... <p style="text-align: center;">-or-</p> MenQuadfi.....	Date: ____ <p style="text-align: center;">-or-</p> Date: ____ <p style="text-align: center;">-or-</p> Date: ____ <p style="text-align: center;">-or-</p> Signed Waiver: <input type="checkbox"/>	<ul style="list-style-type: none"> • One dose at age 16 or older for all incoming students age 21 or younger • Second dose highly recommended <p style="text-align: center;">-or-</p> Signed waiver. Go to the “Forms” tab on the Patient Portal
Varicella (Chicken Pox) <p style="text-align: center;">-or-</p> Positive titer <p style="text-align: center;">-or-</p> History of disease	#1 ____ #2 ____ <p style="text-align: center;">-or-</p> Positive Titer – date: ____ <p style="text-align: center;">-or-</p> History of disease: <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, date: ____	<ul style="list-style-type: none"> • First dose given after 1st birthday • Minimum of 3 months between doses if given between 1-12 years old • Minimum of 4 weeks between doses if given at 13 or older <p style="text-align: center;">-or-</p> Positive titer (blood test for immunity) <p style="text-align: center;">-or-</p> History of disease
Hepatitis B -or- Hepatitis A and B combined <p style="text-align: center;">-or-</p> Heplisav B®..... <p style="text-align: center;">-or-</p> Positive titer.....	#1 ____ #2 ____ #3 ____ <p style="text-align: center;">-or-</p> #1 ____ #2 ____ <p style="text-align: center;">-or-</p> Positive anti-HBs titer – date: ____	Three doses Hepatitis B or Hep A & B combined <ul style="list-style-type: none"> • Usual schedule at 0, 1 and 4-6 months <p style="text-align: center;">-or-</p> Two doses <ul style="list-style-type: none"> • Minimum of 4 weeks between doses <p style="text-align: center;">-or-</p> Positive titer (blood test for immunity)

HIGHLY RECOMMENDED IMMUNIZATIONS 2023-2024

COVID-19 Initial Vaccine Series Moderna..... -or- Pfizer.....	#1 _/_/_ #2 _/_/_ -or- #1 _/_/_ #2 _/_/_	Two doses
COVID-19 Booster Dose Moderna..... Pfizer.....	Date: _/_/_ -or- Date: _/_/_	One dose 5 months after completing initial COVID-19 vaccine series
Influenza	Date: _/_/_	Seasonal influenza vaccine is highly recommended for all students. Vaccine will be available on campus.
Meningococcal Group B MenB-4C (Bexsero®)..... -or- MenB-FHbp (Trumenba®).....	#1 _/_/_ #2 _/_/_ -or- #1 _/_/_ #2 _/_/_ #3 _/_/_	Two doses at least one month apart -or- Three doses at zero, two and six months
Human Papillomavirus (HPV)	#1 _/_/_ #2 _/_/_ #3 _/_/_	<ul style="list-style-type: none"> Three doses Usually schedule at zero, two and six months
Td <i>Tetanus and Diphtheria</i>	Date of most recent booster dose: _/_/_	
Hepatitis A	#1 _/_/_ #2 _/_/_	
Other vaccinations: <ul style="list-style-type: none"> Pneumonia..... Typhoid..... Other: _____ 	Date: _/_/_ Date: _/_/_ Date: _/_/_	

If there is a medical contraindication to any immunization, explain: _____

Healthcare provider signature: _____ Date: _/_/_

Printed Name

Signature

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Alternatively, fax this form to the Student Immunization Program at 413-577-3252, or mail or bring to:
Student Immunization Program, University Health Services, 150 Infirmary Way, Amherst MA 01003-9288