Student Immunization Program
University Health Services
150 Infirmary Way, Amherst, MA 01003-9288
University of Massachusetts Amherst
Phone: 413-545-8871 | Fax: 413-577-3252 | Website: umass.edu/uhs/immunizations
Send us a message: umass.medicatconnect.com *(Go to Action Items > Messages)*

REQUIRED IMMUNIZATIONS FORM (2024-2025)

These vaccines are required by the Commonwealth of Massachusetts. If you haven't received all vaccines, you should still submit this form and receive the remaining vaccines at a later date while on campus at University Health Services.

1. Complete this form with your licensed medical provider.
2. Login to https://umass.medicatconnect.com (choose "I have a UMass NetID" to login). Go to Action Items > Immunizations.
3. Manually enter your information into the fields under **Required Vaccines**, **Highly Recommended Vaccines**, and **Tuberculosis Questionnaire**. Enter all dates, then click SUBMIT once.
4. You will be taken to the Upload section of the portal. Upload a photo or scan of this form and any supporting documents.

Student Last Name: **First Name:** **Middle Name:**

Date of Birth (mm/dd/yyyy) **SPIRE ID Number** **Semester Start (check one)**

☐ Fall ☐ Spring ☐ Summer 20___

Measles-Mumps-Rubella (Required)	2 doses given at least 28 days apart and after 12 months of age. If given as single antigen vaccine, 2 Measles, 2 Mumps and 2 Rubella doses are required OR positive MMR antibody titer. Doses of Varicella and MMR must be given on the same day or 28 days apart. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.			
MMR	Dose 1 (mm/dd/yyyy) ___ /___ /_____	Dose 2 (mm/dd/yyyy) ___ /___ /_____		
OR				
Measles	Dose 1 (mm/dd/yyyy) ___ /___ /_____	Dose 2 (mm/dd/yyyy) ___ /___ /_____	OR	Positive Titer (mm/dd/yyyy) ___ /___ /_____
Mumps	Dose 1 (mm/dd/yyyy) ___ /___ /_____	Dose 2 (mm/dd/yyyy) ___ /___ /_____	OR	Positive Titer (mm/dd/yyyy) ___ /___ /_____
Rubella	Dose 1 (mm/dd/yyyy) ___ /___ /_____	Dose 2 (mm/dd/yyyy) ___ /___ /_____	OR	Positive Titer (mm/dd/yyyy) ___ /___ /_____

Meningococcal: MenACWY or MenABCYW (Required)	One dose on or after your 16th birthday is required. Do not complete this section if you will be over 21 years of age at the start of your first semester. The Meningococcal B vaccine does not fulfill the requirement.
Which vaccine did you receive? ☐ Menactra/Menveo ☐ Menomune ☐ MenQuadfi ☐ Penbraya	___ /___ /_____ (mm/dd/yyyy)
OR	
Signed waiver	☐ Login to umass.medicatconnect.com and go to Action Items > Forms to submit waiver.
Tetanus-Diphtheria-Pertussis (Tdap) (Required)	One dose on or after your 11th birthday is required. If you received multiple doses of Tdap, include most recent dose.
Tdap	___ /___ /_____ (mm/dd/yyyy)

Varicella (Required)	Two doses given at least 4 weeks apart and after 12 months of age OR positive Varicella antibody titer OR a history of the disease verified by your provider. Doses administered at less than the minimum interval or earlier than the minimum age are not valid and must be repeated.					
Varicella	Dose 1 mm/dd/yyyy ___ /___ /____	Dose 2 mm/dd/yyyy ___ /___ /____	OR	Positive Titer mm/dd/yyyy ___ /___ /_____	OR	Disease Date mm/dd/yyyy ___ /___ /_____

Hepatitis B (Required)	A minimum of 4 weeks between doses 1 and 2 and a minimum of 16 weeks between doses 1 and 3 or a positive Hepatitis B antibody titer. ☐ Please check here if you received Hepsilav-B (HepB-CpG). ☐ Please check here if you received the combination hepatitis A & B vaccine (TwinRix).				
Hepatitis B	Dose 1 mm/dd/yyyy ___ /___ /____	Dose 2 mm/dd/yyyy ___ /___ /____	Dose 3 mm/dd/yyyy ___ /___ /_____	OR	Antibody Titer mm/dd/yyyy ___ /___ /_____

CONTINUED ON NEXT PAGE; PROVIDER SIGNATURE REQUIRED

Name: _____ **Date of Birth:** _____ **SPIRE ID:** _____

The following vaccines are not required, but are highly recommended:

COVID-19	☐ Moderna ☐ Pfizer ☐ Other: _____		
	Date of most recent dose: ___ /___ /____ (mm/dd/yyyy)		
Hepatitis A	Dose 1: ___ /___ /____ (mm/dd/yyyy)	Dose 2: ___ /___ /____ (mm/dd/yyyy)	
Human Papillomavirus (HPV)	3 doses; usually scheduled at 0, 2 and 6 months.		
	Dose 1 (mm/dd/yyyy) ___ /___ /____	Dose 2 (mm/dd/yyyy) ___ /___ /____	Dose 3 (mm/dd/yyyy) ___ /___ /____
Influenza	Seasonal flu vaccine is highly recommended for all students. Vaccine will be available on campus.		
	Date of most recent dose: ___ /___ /____ (mm/dd/yyyy)		
Meningococcal Group B	**MenB-4C:** 2 doses at least 1 month apart **MenB-FHbp:** 3 doses at 0, 2 and 6 months		
MenB-4C (Bexsero)	Dose 1: ___ /___ /_____ (mm/dd/yyyy)	Dose 2: ___ /___ /_____ (mm/dd/yyyy)	
OR			
MenB-FHbp (Trumenba)	Dose 1 (mm/dd/yyyy) ___ /___ /_____	Dose 2 (mm/dd/yyyy) ___ /___ /_____	Dose 3 (mm/dd/yyyy) ___ /___ /_____
Tetanus & Diphtheria (Td)	Date of most recent booster: ___ /___ /____ (mm/dd/yyyy)		
Pneumonia	___ /___ /____ (mm/dd/yyyy)		
Typhoid	___ /___ /____ (mm/dd/yyyy)		
Other: _____	___ /___ /____ (mm/dd/yyyy)		

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

_____

TUBERCULOSIS QUESTIONNAIRE (REQUIRED)

1. Have you worked or lived with someone with active TB (or will you prior to your arrival in the US)?		☐ Yes ☐ No	If yes, explain:
2. Were you born in, lived in, or have you traveled for more than 1 month to any of the high-risk countries found here: **umass.edu/uhs/TB**		☐ Yes ☐ No	If yes, explain:
3. Have you ever tested positive for TB or completed 6-9 months of medication to prevent active TB? (i.e. isoniazid)		☐ Yes ☐ No	If yes, explain:
TB Test History	• If you answered **no to all questions** above, skip the remaining questions & obtain provider signature. • If you answered **yes to questions 1 and 2** above, a TB skin test or IGRA blood test must be completed no more than six months prior to the semester start date. Testing is available at UMass. • If you answered **yes to question 3 above** and have ever had a positive TB test in the past, do not repeat a TB test; fill out the Positive TB Test History section below.		
TB Skin Test	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Positive ☐ Negative ☐ Indeterminate	
OR			
IGRA Blood Test	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Positive ☐ Negative ☐ Indeterminate	
Positive TB Test History	Please complete this section if you have ever had a positive TB skin test and/or have ever received treatment for TB.		
Chest X-Ray	Date Given (mm/dd/yyyy) __ / __ / ____	Result: ☐ Normal ☐ Abnormal Describe:	
Clinical Evaluation	Date of Appointment (mm/dd/yyyy) __ / __ / ____	Result: ☐ Normal ☐ Abnormal Describe:	
Treatment	Date of Treatment (mm/dd/yyyy) __ / __ / ____	☐ **Yes** If yes, drug, dose & frequency:	☐ **No** If no, reason why treatment not done:

LICENSED MEDICAL PROVIDER (MD, DO, PA, NP, RN OR MBBS) VERIFICATION (REQUIRED):

_____

Provider Printed Name *Provider Signature/Credentials*

Provider Phone: _____ Date: _____