



# Proof of Immunizations-Massachusetts

Office of Student Affairs  
500 Rutherford Avenue  
Boston, MA 02129  
Phone: 617-873-0614  
studentaffairs@cambridgecollege.edu

In compliance with the Department 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. Every dose and date of each immunization listed on this form are REQUIRED.**  
Student and physician/nurse must SIGN below.

**Student ID#:** \_\_\_\_\_

Academic program: \_\_\_\_\_ School: \_\_\_\_\_

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Middle name: \_\_\_\_\_

Current address: \_\_\_\_\_ Apt. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ (MM/DD/YYYY)

Student signature: \_\_\_\_\_  
Date (mm/dd/yyyy): \_\_\_\_\_

**I am a full-time student:**  
 Undergraduate taking 12 credits or more per academic semester;  
 Graduate taking 8 credits or more per academic semester;  
 I am a part-time student, taking fewer credits per academic semester;

**Exemptions:**

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

Birth before 1956

Your physician, who had previously examined you, is of the opinion that your health would be endangered by the required immunizations (you must submit a letter from your doctor)

Conflict with religious beliefs (written statement required)

**Immunizations required (provide a date for each dose of every vaccination below):**

TWO MMR (Measles, Mumps, Rubella) vaccines:  
MMR dose 1: \_\_\_\_\_ MMR dose 2: \_\_\_\_\_  
 OR serology test date: \_\_\_\_\_  
 OR birth before 1957 in the US

ONE Tdap (tetanus, diphtheria, pertussis) booster:  
 Tdap date: \_\_\_\_\_  Or TD date: \_\_\_\_\_

THREE Hepatitis B vaccines (Adolescent series 2 doses):  
Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_ Dose 3: \_\_\_\_\_  
 OR serology test (titer) date: \_\_\_\_\_  
 Mark here if adolescent series

TWO Varicella (Chicken Pox) vaccines:  
Dose 1: \_\_\_\_\_ Dose 2: \_\_\_\_\_  
 OR Chicken Pox disease date: \_\_\_\_\_  
 OR Varicella titer date: \_\_\_\_\_  
 OR birth before 1980 in the US

**Official signatures**

Physician/Nurse name \_\_\_\_\_

Board of Registration in medicine number: \_\_\_\_\_

Medical practice name: \_\_\_\_\_

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

Physician/Nurse signature: \_\_\_\_\_

Date (mm/dd/yyyy): \_\_\_\_\_

**Please complete, sign and return to:**

\_\_\_\_\_

E-mail to studentaffairs@cambridgecollege.edu, write "Immunizations" in the subject line.

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