BOSTON COLLEGE

University Health Services
140 Commonwealth Ave, Chestnut Hill, MA 02467
Phone: 617-552-3225 Website: bc.edu/uhs
Send us a message: uhs@bc.edu

Documentation of Immunizations

Print Last Name: _____ Print First Name: _____ Eagle ID#: _____

Date of Birth: _____ Cell Phone #: _____ Student Signature: _____

Status (check all that apply):

☐Undergraduate ☐Graduate ☐Evening ☐Exchange ☐Varsity Athlete

Required Immunizations

The Commonwealth of Massachusetts and Boston College require full-time undergraduate students, full-time graduate students 30 years old and under, part-time health science students, and all international students to be immunized against certain communicable diseases. All dates must include month, day, and year. To comply, have this form completed and signed by your healthcare provider OR provided a vaccination record including all of below vaccines. Once completed by the provider, the student must upload all documents to Health Services Portal no later than July 1 for Fall Enrollment and January 1 for Spring Enrollment. If you do not comply, you will be unable to register for the following semester's classes, and a $95 non-refundable late fee will be applied to your student account.

Required Vaccines	Dates Given	MA State Requirements
Hepatitis B Series of 3 immunizations – laboratory evidence for immunity is acceptable in lieu of immunization.	**Vaccine Name:** _____ #1 _____#2_____ #3_____ Or Positive Titer HBs AB Date: _____	Dose #1: any age Dose #2: 28 days after dose #1 Dose#3: least 16 weeks (112 days) between doses #1 and #3 2 doses of Heplisav-B given on or after 18 years of age are acceptable
Meningococcal Quadrivalent Required for students 21 years of age and younger.	#1 _____ Please check which vaccine was administrated: ☐Menactra or ☐Menveo ☐Nimenrix or ☐signed waiver	1 dose MenACWY (formerly MCV4) on or after age 16 or a Signed Waiver
MMR (Measles, Mumps & Rubella) Or Individual vaccines or titers: Measles, Mumps, Rubella	**MMR:** #1 _____#2_____ **Measles:** #1 _____#2_____Or Positive Titer Date: _____ **Mumps:** #1 _____#2_____Or Positive Titer Date: _____ **Rubella:** #1 _____#2_____Or Positive Titer Date: _____	Dose #1 must be given on or after the 1st birthday Dose #2 must be given ≥28 days after the first dose Or laboratory evidence of immunity is acceptable.
Tdap (Tetanus, Diphtheria, Pertussis)	Tdap: _____	Tdap must have been given on or after the age of 7.
Varicella Vaccination laboratory evidence for immunity is acceptable in lieu of immunization. Or History of Chickenpox	#1 _____#2_____Or Positive Titer Date: _____ Or History of disease: ☐Yes ☐No Age: _____Date: _____	Dose #1: on or after the first birthday Dose #2: at least 28 days after dose #1 Medical record documentation signed by the provider required for a history of chickenpox or laboratory evidence of immunity is acceptable
Strongly Recommended/ Additional Immunizations & Standard Dosing		
COVID – 19 Vaccine & Booster	Vaccine Manufacturer: _____ #1 _____#2_____ Booster Manufacturer: _____ Booster: _____	**Accepted Vaccines:** Pfizer-BioNTech/Moderna/Johnson & Johnson's Janssen/ WHO EUL Vaccine
Gardasil (HPV) Human Papillomavirus	#1 _____#2_____ #3_____	3 doses over 6 months
Hepatitis A	#1 _____#2_____	Hep A: 2 doses at least 6 months apart
Hepatitis A & B Combined	#1 _____#2_____ #3_____	Hep A & B Combined: 3 doses given on a 0, 1, and 6-month schedule
Influenza	Vaccines for the current flu season should be received annually by December 31st	Once received, upload documentation and enter the date in the UHS Portal.
Meningococcal Group B MenB-4C (Bexsero)	#1 _____#2_____	2 doses. second dose at least 1 month after the first dose.
Meningococcal Group B MenB-FHbp (Trumenba)	#1 _____#2_____ #3_____	2 or 3 doses. For those not at risk, 2 doses, second dose 6 months after the first dose. Those increased risk 3 doses. Second dose 1-2 months after the first dose. Third dose 6 months after the first.
Td/Tdap (Tetanus, Diphtheria, Pertussis)	Td: _____or Tdap: _____	An updated Td/Tdap is recommended every 10 years.

Licensed Medical Provider (MD, DO, PA, NP, RN, MBBS) Verification
Required

Provider's Printed Name _____ Date: _____

Address (including City & State): _____ Phone #: _____

Provider's Signature/Credentials: _____