UMassAmherst

University Health Services
(413) 577-5000 www.umass.edu/uhs

Last Name | First Name | Date of Birth | Student ID #

REQUIRED IMMUNIZATIONS 2021-2022

Massachusetts state law requires submission of the following immunizations or proof of immunity for admission. Have your healthcare provider complete and sign this form, or attach immunization documents from your provider, school or military sources in lieu of signature.

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 *Measles, Mumps and Rubella, combined* -or- *Individual vaccines or positive titers* **Measles** **Mumps** **Rubella**	#1 3/3/98 #2 3/24/03 -or- #1 __/__/__ #2 __/__/__ Or positive titer – date: __/__/__ #1 __/__/__ #2 __/__/__ Or positive titer – date: __/__/__ #1 __/__/__ #2 __/__/__ Or positive titer – date: __/__/__	Two doses: • Minimum of four weeks between doses • First dose given after 1st birthday -or- Individual vaccines -or- Positive titers (blood tests for immunity)
Tdap *Tetanus, Diphtheria, Pertussis*	Date: 1/3/20	One dose
Meningococcal: MenACWY *Meningitis vaccine* Menactra®/Menveo® -or- Menomune® -or- MenQuadfi	Date: 5/2/15 -or- Date: __/__/__ -or- Date: __/__/__ -or- Signed Waiver: ☐	• One dose at age 16 or older for all incoming students age 21 or younger • Second dose highly recommended -or- Signed waiver. Go to the "Forms" tab on the Patient Portal/
Varicella (Chicken Pox) -or- Positive titer -or- History of disease	#1 1/21/98 #2 10/16/07 -or- Positive Titer – date: __/__/__ -or- History of disease: ☐ No ☐ Yes If yes, date: __/__/__	• 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 -or- Positive titer (blood test for immunity) -or- History of disease

Required Vaccines	Dates Given	MA State Requirements
Hepatitis B -or- Hepatitis A and B combined -or- Heplisav B®..... -or- Positive titer.....	#1 12/6/96 #2 2/7/97 #3 9/9/97 -or- #1 __/__/__ #2 __/__/__ -or- Positive anti-HBs titer – date: __/__/__	Three doses Hepatitis B or Hep A & B combined • Usual schedule at zero, one and four-six months -or- Two doses • Minimum of four weeks between doses -or- Positive titer (blood test for immunity)

HIGHLY RECOMMENDED IMMUNIZATIONS

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
Second dose Meningococcal: MenACWY Menactra®/Menveo®..... -or- Menomune®..... -or- MenQuadfi.....	Date: __/__/__ -or- Date: __/__/__ -or- Date: __/__/__	
Human Papillomavirus (HPV)	#1 __/__/__ #2 __/__/__ #3 __/__/__	• Three doses • Usually schedule at zero, two and six months
Td *Tetanus and Diphtheria*	Date of most recent booster dose: __/__/__	
Hepatitis A	#1 10/10/07 #2 4/21/08	
Other vaccinations: • Pneumonia..... • Typhoid..... • Other: _____	Date: __/__/__ Date: __/__/__ Date: __/__/__	

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

Healthcare provider signature: Dr. Emily Perkins MD **Date:** 7/12/21

Printed Name *Signature*

PEDIATRIC HEALTHCARE ALLIANCE
4446 E. FLETCHER AVE. SUITE A

Pediatric Health Care Alliance, P.A. - Northside Office
4446 East Fletcher Ave. Suite A, Tampa, FL 33613-4942
(813) 971-6700 Fax: (813) 977-1352

Immunization Report

DESIREE D SMITH
2009 E CLIFTON ST
TAMPA, FL 33610

Date of Birth: 12/03/1996
Responsible Provider: Emily Taylor Perkins
Social Security Number:

IMMUNIZATION	DATE ADMINISTERED	VALUE
chicken pox immunization #1	01/21/1998	given
chicken pox immunization #2	10/16/2007	given
DPT immunization #1	02/07/1997	given
DPT immunization #2	04/02/1997	given
DTaP (Diphtheria, Tetanus, and acellular Pertussis) immunization #3	05/27/1997	given
DTaP (Diphtheria, Tetanus, and acellular Pertussis) immunization #4	07/16/1998	given
DTaP (Diphtheria, Tetanus, and acellular Pertussis) immunization #5	03/19/2002	given
Hemophilus influenza B immunization #1	02/07/1997	given
Hemophilus influenza B immunization #2	04/02/1997	given
Hemophilus influenza B immunization #3	05/27/1997	given
Hemophilus influenza B immunization #4	03/03/1998	given
hepatitis A immunization #1	10/16/2007	given
hepatitis A immunization #2	04/21/2008	given
hepatitis B vaccine #1 given	12/06/1996	given
hepatitis B vaccine #2 given	02/07/1997	given
hepatitis B vaccine #3	09/09/1997	given
Human Papillomavirus vaccine #1, (HPV #1) Drug Name	10/16/2007	given
Human Papillomavirus vaccine (Gardasil) #2, (HPV #2) Drug Name	12/17/2007	given
Human Papillomavirus vaccine (Gardasil) #3, (HPV #3) Drug Name	04/21/2008	given
influenza immunization #2	11/17/2008	given
influenza immunization #3	12/20/2010	given
influenza immunization #3	09/08/2012	given
influenza immunization #3	12/26/2014	given
influenza immunization (Flu Vax) has been administered	10/16/2007	given
Menactra (meningococcal conjugate vaccine), Dose 1 given	05/04/2009	given
Menactra (meningococcal conjugate vaccine), Dose 2 given	05/02/2015	given
MMR (measles, mumps, rubella) virus immunization #1	03/03/1998	given
MMR (measles, mumps, rubella) virus immunization #2	03/24/2003	given
oral polio vaccine (OPV) #1	02/07/1997	given
oral polio vaccine (OPV) #2	04/02/1997	given
oral polio vaccine (OPV) #3	07/16/1998	given
polio vaccine #4	03/19/2002	given
Tetanus toxoid, reduced diphtheria toxoid and acellular Pertussis vaccine, absorbed (TdaP) given	05/04/2009	given

COVID-19 Vaccination Record Card

Please keep this record card, which includes medical information about the vaccines you have received.

Por favor, guarde esta tarjeta de registro, que incluye información médica sobre las vacunas que ha recibido.

Smith — Last Name
Desiree — First Name
MI

12/3/96 — Date of birth
Patient number *(medical record or IIS record number)*

Vaccine	Product Name/Manufacturer Lot Number	Date	Healthcare Professional or Clinic Site
1st Dose COVID-19	PFIZER LOT# EN6208	APR 1 0 2021 mm dd yyyy	AHMG TAMPA
2nd Dose COVID-19	PFIZER LOT# EP7533	MAY 1 0 2021 mm dd yyyy	ADVENTHEALTH TAMPA
Other		__/__/__ mm dd yy	
Other		__/__/__ mm dd yy	

Reminder! Return for a second dose!
¡Recordatorio! ¡Regrese para la segunda dosis!

Vaccine	Date / Fecha
COVID-19 vaccine Vacuna contra el COVID-19	MAY 10 2021 mm dd yy
Other Otra	___/___/___ mm dd yy

Bring this vaccination record to every vaccination or medical visit. Check with your health care provider to make sure you are not missing any doses of routinely recommended vaccines.

For more information about COVID-19 and COVID-19 vaccine, visit **cdc.gov/coronavirus/2019-ncov/index.html.**

You can report possible adverse reactions following COVID-19 vaccination to the Vaccine Adverse Event Reporting System (VAERS) at **vaers.hhs.gov.**

Lleve este registro de vacunación a cada cita médica o de vacunación. Consulte con su proveedor de atención médica para asegurarse de que no le falte ninguna dosis de las vacunas recomendadas.

Para obtener más información sobre el COVID-19 y la vacuna contra el COVID-19, visite **espanol.cdc.gov/coronavirus/2019-ncov/index.html.**

Puede notificar las posibles reacciones adversas después de la vacunación contra el COVID-19 al Sistema de Notificación de Reacciones Adversas a las Vacunas (VAERS) en **vaers.hhs.gov.**

09/03/20

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