FITCHBURG STATE UNIVERSITY

Name (Printed): Anumolu Nanda Kishore DOB: 19-01-2001

Immunization requirements apply to all full time undergraduate and graduate students, all part-time health science students, students here on a visa and all residential students. 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 vaccination documents from your provider, school or military sources in lieu of signature. All titers must have a laboratory report attached. Incomplete forms will not be accepted and student will not be allowed on campus.

IMMUNIZATION RECORD

MMR (Measles/Mumps/Rubella) – 2 doses required

MMR #1 _____/_____/_____
MMR #2 _____/_____/_____
OR
Positive (+) MMR Blood Titer accepted in place of vaccines
_____/_____/_____ (Attached lab report)

TDAP (Tetanus/Diphtheria/Acellular/Pertussis)

_____/_____/_____ (last dose within the last 10 years)

MENINGITIS (MenACWY or MCV4)

_____/_____/_____ (applies to all students 21 year and younger. Must be given on or after age 16)
OR
Signed Meningococcal Waiver
(Meningococcal B vaccine is not required and
does not meet this requirement)

HEPATITIS B – 3 doses required

HEP B #1 _____/_____/_____
HEP B #2 _____/_____/_____
HEP B #3 _____/_____/_____
OR
Positive (+) Hepatitis B Blood Titer accepted in place of vaccines
_____/_____/_____ (Attached lab report)

VARICELLA – 2 doses required

#1 _____/_____/_____
#2 _____/_____/_____
OR
Positive (+) Varicella Blood Titer accepted in place of vaccines
_____/_____/_____ (Attached lab report)
OR
History of the disease verified by healthcare provider
_____/_____/_____

TUBERCULOSIS (TB) **Required for International students**

Test Date: _____/_____/_____
Result: Negative
Positive
PPD (Mantoux) test given within the last six months.
Chest X-ray if TB test is positive (Attached report)

COVID-19

#1 _____/_____/_____
#2 _____/_____/_____ (if applicable)
#3 _____/_____/_____ (BOOSTER-if applicable)

INFLUENZA (FLU) ***HIGHLY RECOMMENDED***

_____/_____/_____ (Seasonal influenza vaccine for the current flu season formulation)

*********I attest that the above information is accurate and complete**********

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

Printed name: DR. M. VIJAYA RAMAN (M.B.B.S., D.G.O) Phone: ( ) _____