Anna Maria College
Health Services
50 Sunset Lane, Paxton, MA 01612
Phone: 508-849-3315
Email: healthservices@annamaria.edu

IMMUNIZATION RECORD

To be completed by a licensed health care provider
All information must be in English
dates must include month, day, and year

In accordance with Massachusetts State Law, Anna Maria College requires all students to submit documentation of Immunizations to Health Services. Students must input individual immunization dates in the online Medicat Patient Portal AND upload a scanned copy of their immunization record

Student/Patient Information (please print)

Legal Name	Preferred Name
Date of Birth	Anna Maria College Student ID#

REQUIRED Immunizations – prior to matriculation

MMR (Measles, Mumps, Rubella): *two doses given at least 4 weeks apart required*
Dose 1 given at Age 12-15 months or later. #1 _____
Dose 2 given at age 4-6 years or later and at least one month after 1st dose. #2 _____
OR attach laboratory results of measles, mumps, and rubella immunity. [ ] Titer results attached

Tetanus/Diphtheria/Pertussis:
Tdap _____ at least one dose of Tdap vaccine in a lifetime. List most recent dose.
Tetanus Booster (Td or Tdap) _____ *Required if it has been 10 years or more since Tdap was given*
Primary series of 4 doses with DTaP or DTP

#1 _____ #2_____ #3_____ #4_____

Hepatitis B: *three dose series required*
#1 _____ #2_____ #3_____
OR Adult Heplisav-B *2 dose series* given on or after age 18 #1 _____ #2_____
OR attach laboratory results of Hepatitis B immunity [ ] Titer results attached

Meningococcal Vaccine: *one dose of quadrivalent vaccine MenACWY (previously MCV4) required for 21 years of age or younger. Must be given on or after 16th birthday.* MenACWY vaccine: _____

Varicella: *two doses given at least 4 weeks apart required*
Dose 1 given on or after 1st birthday. #1 _____
Dose 2 given at least 28 days after first dose. #2 _____
OR history of Varicella disease. Date of diagnosis: _____
OR attach laboratory results of Varicella immunity [ ] Titer results attached

Highly Recommended Immunizations

COVID-19: Vaccine type _____ Dose #1 _____ Dose #2 _____
Booster type(s) & date(s) _____
Influenza: Dose received on or after August 1st of current influenza season _____

Provider Signature:	Provider Name *(please print):*	
Street Address:		
City:	State:	Zip Code:
Phone:	Fax:	