

FISHER COLLEGE STUDENT IMMUNIZATION FORM

Health Services | 118 Beacon Street | Boston, Massachusetts 02116
 Phone: 617-236-8860 | Fax: 617-236-5465

Please return directly to
 Fisher College Health Services.



This form must be completed and returned to Health Services before you arrive on campus. All responses must be in English.

- You may:
- 1) Complete the student information section. Attach immunization documentation from your healthcare provider's office, school, or military records, or
 - 2) Complete the student information section. Have your healthcare provider complete the remaining sections and sign where indicated, or
 - 3) Email the completed forms to healthservices@fisher.edu.

STUDENT INFORMATION

First Name _____		Last Name _____	
/ /			
Date of Birth _____	Home Phone # _____	Cell Phone # _____	
Home Address _____			
City _____		State _____	Zip _____

REQUIRED IMMUNIZATIONS**Tetanus / Diphtheria/ Acellular Pertussis** (one booster)

TDaP ____ / ____ / ____ (within 10 years)
 MM DD YY

TD ____ / ____ / ____
 MM DD YY

Meningitis ACWY

Vaccine ____ / ____ / ____ Type _____ (refer to enclosed guidelines)
 MM DD YY

*One dose of MenACWY for newly enrolled full-time students 21 years of age and younger (<22 years of age) received on or after the 16th birthday, regardless of housing status or signed waiver (on page 12).

Varicella (Two doses required)

☐ Varicella #1: ____ / ____ / ____ #2: ____ / ____ / ____
 MM DD YY MM DD YY

or

☐ Positive Blood Titer: ____ / ____ / ____ (attach copy of lab results)
 MM DD YY

☐ Had disease (Chickenpox) ____ / ____ / ____
 MM DD YY

Measles - Mumps - Rubella (MMR) (Two doses required)

MMR#1: ____ / ____ / ____ (First dose must be after age 12 months) MMR#2: ____ / ____ / ____ (Must be at least one month after dose #1)
 MM DD YY MM DD YY

or

☐ Positive Blood Titers: (attach copy of lab results)

Measles (Rubeola): ____ / ____ / ____ Mumps: ____ / ____ / ____ Rubella: ____ / ____ / ____
 MM DD YY MM DD YY MM DD YY

Hepatitis B (Three doses required)

#1: ____ / ____ / ____ #2: ____ / ____ / ____ (Must be at least one month after dose #1) #3: ____ / ____ / ____ (Must be at least two months after dose #2 and four months after #1)
 MM DD YY MM DD YY MM DD YY

or

☐ Positive Blood Titer: ____ / ____ / ____ (attach copy of lab results)
 MM DD YY

RECOMMENDED IMMUNIZATIONS**Covid Vaccine**

#1 ____ / ____ / ____ #2 ____ / ____ / ____
 MM DD YY VERSION MM DD YY VERSION

#3 ____ / ____ / ____
 MM DD YY VERSION

Influenza

Vaccine ____ / ____ / ____
 MM DD YY

Health Care Provider (please print)

Address

Phone/Fax

Provider's Signature