Cape Cod Community College

2240 Iyannough Rd., W. Barnstable, MA 02668

General Student Immunization Requirements

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Massachusetts General Law 105 CMR 220.600 requires all full time students (12 credits or more) provide the following record of immunizations. Health Science students require additional immunizations. Completed forms are necessary to demonstrate compliance with the law.

THIS SECTION COMPLETED BY STUDENT

HEALTH RECORD RETENTION POLICY: All students are encouraged to establish a personal file for their medical records. Make a copy of this form prior to submitting. The college may charge a fee for students to receive a copy of this form. Immunization records are retained by the college for five (5) years only.

Last Name: ___________________________ First: ____________________M: ____ Maiden/Other Name:________________

Phone: _______________________Date of Birth: _____________________ Student ID Number: ___________________

Program of Study: ________________________ Signature: __________________________________ Date: ______________

Signing this form authorizes the release of immunization records/information to Cape Cod Community College.

Required Vaccines: Students must have proof of one injection of Td (tetanus/diphtheria) within five years or Tdap (tetanus w/pertussis) within 10 years, two injections of MMR, three injections of Hepatitis B, and two injections of Varicella. Proof of immunity by laboratory titre is acceptable for MMR, Hepatitis B, and Varicella. Birth in the United States prior to 1980 for Varicella and 1957 for MMR is acceptable proof of immunity **(except for students in Health Science Programs)**.

Immunization Requirements for all full time (12 credits or more) general student population.	**Dates:**
Hepatitis B Or laboratory titre (please provide lab report)	1. ____________ 2. ____________ 3. ____________ Titre: ________________
MMR Measles, Mumps & Rubella Or laboratory titre (please provide lab report)	1. ____________ 2. ____________ Measles Titre : _______________ Mumps Titre : _______________ Rubella Titre : _______________
Tdap (Tetanus w/pertussis) within the last 10 years Or Td (Tetanus/diphtheria) within the last 5 years	_____________________ _____________________
Varicella (Chickenpox) Or laboratory titre (please provide lab report) Or documented history of disease (as defined by DPH… includes a diagnosis of chickenpox, or interpretation of parent/guardian description of chickenpox, by a physician, nurse practitioner, physician assistant or designee)	1. ____________ 2. ____________ Titre: __________________ Disease Date:____________

HEALTHCARE PROVIDER'S SIGNATURE:_____________________________________ **DATE:** ______________

PRINT NAME: ______________________________ **ADDRESS:** ____

PHONE: __________________________