Cape Cod Community College
Health Science Student Immunization Requirements

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Massachusetts General Law 105 CMR 220.600 requires all full time (12 credits or more) and all part time students in a Health Science program 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, and negative annual PPd. Proof of immunity by laboratory titre is acceptable for MMR, Hepatitis B, and Varicella.

Immunization Requirements for Health Science students	**Dates:**
Hb Hepatitis 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 within the last 10 years Or Tetanus (Td) within the last 5 years	_____ _____
Varicella (Chickenpox) Or laboratory titre (please provide lab report)	1. _____ 2. _____ Or Titre: _____
PPd Results: _____ PPd#2 (if required) Results: _____	Date Planted: _____ Date Read: _____ Date Planted: _____ Date Read: _____

HEALTHCARE PROVIDER'S SIGNATURE:_____ **DATE:** _____

PRINT NAME: _____ **ADDRESS:** _____

PHONE: _____

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