

Worcester Polytechnic Institute requires verification of immunizations and/or serological test for Measles, Mumps, and Rubella. Exact dates are required. This form is to be completed by a health care provider. *Please return this form to the student when it is completed. Thank you.*

Student Name: _____ WPI ID# _____
Date of Birth _____

This is **required** by the University; if documentation is not received by the deadline an academic hold may be implemented.

Vaccines Dates Given

MMR#1 ____/____/____ #2 ____/____/____

Measles#1 ____/____/____ #2 ____/____/____ positive titer date ____/____/____

Mumps#1 ____/____/____ #2 ____/____/____ positive titer date ____/____/____

Rubella#1 ____/____/____ positive titer date ____/____/____

2 doses of MMR (Measles, Mumps, Rubella) or positive titers or 2 doses Measles, 2 doses Mumps, and 1 dose Rubella MMR#1 must be given after 1st birthday

Hepatitis B #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
OR positive titer date ____/____/____

All full time students are required to have 3 doses OR Positive Surface Antibody Titer

Tdap/Td

Tdap ____/____/____ Td ____/____/____

**Tdap/Td booster within the last 10 years
Freshman are required to have one dose of Tdap**

Varicella (Chicken Pox)

History of illness: date ____/____/____
OR Immunizations: #1 ____/____/____ #2 ____/____/____
OR positive titer date ____/____/____

Freshman are required to have 2 doses 2 doses of Varicella vaccine, minimum of 4 weeks between doses OR Positive Titer

Meningococcal

Date ____/____/____

Recommended for all 1st year students living in dorms, must sign waiver if not vaccinated.

TST (Tuberculin Skin Test) Mantoux Method

Date administered ____/____/____

Date read: ____/____/____ Results: _____ mm
Chest x-ray date: ____/____/____

Required only if at high risk – see Tuberculosis Risk Questions located online Health History Form. Results must be recorded in the *exact measurement* of induration.

Include copy of chest x-ray report. If positive please provide detailed treatment plan.

History of BCG Date ____/____/____

OTHER:

Vaccine: _____ Date: ____/____/____

Vaccine: _____ Date: ____/____/____

Vaccine: _____ Date: ____/____/____

The above named patient is requesting exemption from the immunizations requirements/recommendations. Please provide proper documentation supporting the exemption(s). Please circle one: Health Religious Other

Health care provider's

(Signature) (Print name) (Date)

Address: _____

Telephone: (_____) _____