Student Immunization Record

WPI Student Health Services
100 Institute Road, Worcester, MA 01609
Tel: 508-831-5520

Name:_____ Date of Birth: _____

Cell Phone: _____ Email: _____

In accordance with Massachusetts State Law, WPI requires all students to submit documentation of immunity to Health Services. The students' health care provider must complete this immunization record **OR** attach a copy of the student's immunization record on office stationary.

REQUIRED VACCINES

Covid-19 Pfizer or Moderna - Dose 1 and 2 at least 3 weeks apart, and a booster dose at least 5 months after dose 2. J&J - 1 dose, and a booster dose at least 2 months after dose 1. Other WHO approved Covid-19 vaccines.	**COVID19** MM/DD/YYYY **Type:** Dose 1_____/_____/_____ Dose 2_____/_____/_____ **COVID19 BOOSTER** MM/DD/YYYY **Type:** Booster_____/_____/_____
Hepatitis B Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 wks. apart: at least 16 weeks between doses 1 and 3. OR Hepatitis immune serology (titer) accepted (attach lab documentation)	**HEP B** MM/DD/YYYY Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____ OR Lab documentation attached (please circle) YES NO
Measles, Mumps, Rubella (MMR) 2 doses MMR Dose 1 after first birthday, Dose 2 at least 1 month after Dose 1 OR MMR immune serology (titer) accepted (attach lab documentation)	**MMR** MM/DD/YYYY Dose 1_____/_____/_____ Dose 2_____/_____/_____ OR Lab documentation attached(please circle) YES NO
Meningococcal Booster ≥ age 16 OR If you choose to waive this vaccine, please download the Meningitis Waiver Form and upload it to the WPI Student Health Portal.	**Menactra/Menomune/Menveo** MM /DD/YYYY Dose 1 _____/_____/_____ OR Waiver attached (please circle) YES NO
Tetanus-Diptheria and Pertussis (Tdap) 1 dose within the past 10 years	**Tdap** MM /DD/YYYY _____/_____/_____
Varicella 2 doses of Varicella at least 4 wks. apart after 12 months of age OR History of disease OR Varicella immune serology (titer) accepted (attach lab documentation)	**Varicella** MM /DD/YYYY Dose 1_____/_____/_____ Dose 2_____/_____/_____ OR Lab documentation attached (please circle) YES NO History of disease_____/_____/_____
OTHER RECOMMENDED VACCINES: **Human Papillomavirus (HPV)** 3 doses of HPV vaccine at 0,1-2,6 month schedule age 9-26 yrs. OR 2 doses before 15th birthday at 0, 6-12 months. **Hepatitis A** 2 doses 6 months apart age 12 months and older **Meningitis B** Trumemba 2 or 3 dose schedule Bexsero 2 doses at least 1 month apart **Influenza** **Pneumococcal** if high risk medical condition	**HPV** MM/DD/YYYY Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____ **Hepatitis A** Dose 1_____/_____/_____ Dose 2_____/_____/_____ **Meningitis B** Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____ **Influenza** _____/_____/_____ **Pneumococcal** _____/_____/_____

Health Care Provider (print)_____Signature_____

Address:_____Phone #_____Fax# _____