

Student Name _____

IMMUNIZATIONS

To be completed by health care provider only

Attention: Required immunizations must be complete before class registration!

Required	Month	Year
MMR (Measles, Mumps, Rubella) 2 doses required.		
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____	_____
<input type="checkbox"/> Dose 2 (Given at least 1 month after Dose 1)	_____	_____
OR		
Measles (If given instead of MMR) 2 doses required		
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____	_____
<input type="checkbox"/> Dose 2 (One month after dose 1)	_____	_____
unable to document 2 Measles Immunization dates, <i>must provide:</i>		
<input type="checkbox"/> Measles Serology Results _____	_____	_____
Mumps (If given instead of MMR) 1 dose required		
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____	_____
If unable to document Mumps Immunization date, <i>must provide</i>		
<input type="checkbox"/> Mumps Serology Results _____	_____	_____
Rubella (If given instead of MMR) 1 dose required		
<input type="checkbox"/> Dose 1 (Immunized on or after first birthday)	_____	_____
If unable to document Rubella Immunization date, <i>must provide</i>		
<input type="checkbox"/> Rubella Serology Results _____	_____	_____

Required

TDAP (Tetanus, Diphtheria, Pertussis)		
<input type="checkbox"/> Single Dose required	_____	_____

Hepatitis B		
<input type="checkbox"/> Primary Series #1 _____ #2 _____ #3 _____		
If unable to document dates, titer required (COMPLETED)		
<input type="checkbox"/> Hepatitis B Serology Results _____	_____	_____

Varicella		
<input type="checkbox"/> Vaccine, 1 st dose	_____	_____
<input type="checkbox"/> Vaccine, 2 nd dose	_____	_____
OR		
<input type="checkbox"/> History of Disease	_____	_____
<input type="checkbox"/> Serology/Results _____	_____	_____

Meningococcal Polysaccharide Vaccine (Meningitis) – For Residence Hall Only		
<input type="checkbox"/> Dose 1	_____	_____

Optional

PPD / Results _____	_____	_____
<input type="checkbox"/> Chest X-ray (if positive PPD) Results _____	_____	_____
<input type="checkbox"/> Completed course of INH yes ___ no ___	_____	_____

Signature of Health Care Provider

Address

I authorize my health care provider to release the information above to the School of the Museum of Fine Arts, Boston for their records:

(Student Signature)

Please fax to (617) 369-4264, Attention: Admissions Department

