Massachusetts College of Pharmacy & Health Sciences

FORM B

Student Immunization Form

Name: ____ ________________

Last First Middle Date of Birth

Address: ____

Street City State Zip

MCPHS University ID# ____________________

- This form must be completed by your healthcare provider.
- Submit all information to CastleBranch via www.castlebranch.com. Please direct all questions to CastleBranch at 888.914.7279 or customerservice@castlebranch.com
- Students: Keep a copy for your own records. Records must be sent electronically to CastleBranch.
- All information must be in English.
- If taking this form to a healthcare provider, students are encouraged to bring a copy of their existing immunization records.

MEASLES, MUMPS, RUBELLA (MMR): 2 doses given at least one month apart required **or** laboratory evidence of immunity. First dose of MMR must be administered on or after the student's 1st birthday.	**MMR #1 Date:** ___/___/___ **MMR #2 Date:** ___/___/___ **OR** **Measles Titer: Date:** ___/___/___ ___Immune ___Non-Immune **Mumps Titer: Date:** ___/___/___ ___Immune ___Non-Immune **Rubella Titer: Date:** ___/___/___ ___Immune ___Non-Immune
TETANUS, DIPHTHERIA, PERTUSSIS: 1 dose of TDaP and either a history of DTaP primary series **or** age-appropriate catch-up vaccination.	**TDaP Date:** ___/___/___ **DTaP #1 Date:** ___/___/___ **DTaP #2 Date:** ___/___/___ **DTaP #3 Date:** ___/___/___ **DTaP #4 Date:** ___/___/___ **DTaP #5 Date:** ___/___/___ Catch-up vaccination: ______________
VARICELLA (CHICKEN POX): 2 doses given at least 1 month apart required; laboratory evidence of immunity; or physician diagnosis of varicella. First dose must be administered on or after the student's 1st birthday.	**Varicella #1 Date:** ___/___/___ **Varicella #2 Date:** ___/___/___ **OR** **Varicella Titer: Date:** ___/___/___ ___Immune ___Non-Immune **OR** **History of Varicella disease:** ________________________________
HEPATITIS B: 3 doses of Hepatitis B vaccine **and** a positive Hepatitis B titer **or** 2 doses of Heplisav-B vaccine (first dose must be given on or after the student's 18th birthday) **and** a positive Hepatitis B surface antibody titer.	**#1 Date:** ___/___/___ **#2 Date:** ___/___/___ **#3 Date:** ___/___/___ **OR** **Heplisav-B: #1 Date:** ___/___/___ **#2 Date:** ___/___/___ **AND** **Hep. B Titer: Date:** ___/___/___ ___Positive ___Negative
MENINGOCOCCAL: 1 dose MenACWY (formerly MCV4) required for students under age 22 on the first day of the semester. Must have been administered on or after the student's 16 birthday. Meningococcal B vaccine does not meet this requirement.	**Meningococcal ACWY Date:** ___/___/___
TUBERCULOSIS SCREENING: PPD is required regardless of BCG inoculation**. If PPD is positive, chest x-ray is required.** **For Nursing, Occupational Therapy, and Physical Therapy students only:** documentation of 2 PPD tests, 1-3 weeks apart, administered within the last 12 months and then 1 step PPD tests repeated annually.	**TB Step 1: Date of Plant:** ___/___/___ **Date Read:** ___/___/___ **Result:** _______________ **TB Step 2: Date of Plant:** ___/___/___ **Date Read:** ___/___/___ **Result:** _______________ **X-ray result:** __________________________ **Date:** ___/___/___
INFLUENZA: Required each year for clinical students. If the student chooses to sign a waiver, this could impact academically required rotations.	**Date:** ___/___/___
MEDICAL CLEARANCE STATEMENT: (Required for Physical Therapy and Nursing Students Only) __________________________ (student name) is in good health and can participate in all school and clinical activities without restriction.	

Print Provider's Name: ______________________________ Provider's Signature: ______________________________

Provider's Phone #: ______________________________ Date: ______________________________