FORM A

Massachusetts College of Pharmacy & Health Sciences

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 to 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 required or laboratory evidence of immunity. First dose 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 Varicella disease:** _____
HEPATITIS B: Either 3 doses of Hepatitis B vaccine, 2 doses of Heplisav-B vaccine (first dose must be given on or after the student's 18th birthday) **or** a positive Hepatitis B surface antibody titer.	**Series: #1 Date:** ___/___/___ **#2 Date:** ___/___/___ **3 Date:** ___/___/___ **OR** **Heplisav-B: #1 Date:** ___/___/___ **#2 Date:** ___/___/___ **OR** **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 16th birthday. Meningococcal B vaccine does not meet this requirement.	**Meningococcal:** **Date:** ___/___/___

Print Provider's Name: _____ Provider's Signature: _____

Provider's Phone #: _____ Date: _____