Massachusetts College of Pharmacy & Health Sciences

Student Immunization Form

FORM B

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 records to CastleBranch: **mycb.castlebranch.com**. For technical help, please contact 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.

Comment: *Certain health care agencies, clinical training sites, and service learning locations that host student rotations may require additional immunizations or testing. Students are advised to contact their Clinical Coordinator for further information about meeting those requirements.*

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

Provider's Phone #: _____ Date: _____

Revised May 2025