In accordance with Massachusetts state law, Assumption College requires all students enrolled in 9 or more credits in a semester and all international students regardless of credit load, to submit documentation of immunity to the Graduate Studies Office.

### Required Immunizations

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| **Hepatitis B**                                   | 3 doses required for 20 mcg series; Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 weeks apart; at least 16 weeks between Doses 1 and 3 | Dose 1: _____ / _____ / _____  
                                                                                                  | Dose 2: _____ / _____ / _____  
                                                                                                  | Dose 3: _____ / _____ / _____  
                                                                                                  | OR Lab documentation is attached |
| **Tetanus-Diphtheria and Pertussis (Tdap or Td)**  | 1 dose of Tdap within the past 10 years. OR a Td booster within the past 5 years. | Tdap: _____ / _____ / _____  
                                                                                                  | Td: _____ / _____ / _____  
                                                                                                  | OR Lab documentation is attached |
| **Measles, Mumps, Rubella (MMR)**                 | 2 doses MMR; Dose 1 after 1st birthday; Dose 2 at least one month after Dose 1. OR MMR Immune Serology (titer) accepted OR Lab documentation is attached OR Born in the United States before 1957 | MMR Dose 1: _____ / _____ / _____  
                                                                                                  | MMR Dose 2: _____ / _____ / _____  
                                                                                                  | OR Lab documentation is attached  
                                                                                                  | OR Born in the United States before 1957  
                                                                                                  | Date of Birth: _____ / _____ / _____  
                                                                                                  | OR Lab documentation is attached  
| **Meningococcal Meningitis**                      | 1 dose of MPSV4 in the last 5 years OR 1 dose of MCV4 anytime OR Signed waiver is attached (found on SHS website) | MPSV4 Menomune®: _____ / _____ / _____  
                                                                                                  | OR MCV4 Menactra® or Menveo®: _____ / _____ / _____  
                                                                                                  | OR Waiver is attached |

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| **Varicella (Chicken Pox)**                       | 2 doses of Varicella required; Dose 1 and 2 at least 4 weeks apart OR History of disease OR Varicella Immune Serology (titer) accepted OR Lab documentation is attached | Dose 1: _____ / _____ / _____  
                                                                                                  | Dose 2: _____ / _____ / _____  
                                                                                                  | OR History of Varicella Disease: _____ / _____ / _____  
                                                                                                  | OR Lab documentation is attached |
1. Have you ever had a positive tuberculosis (TB) skin test? Yes ☐ No ☐

2. To the best of your knowledge, have you had close contact with anyone who was sick with TB? Yes ☐ No ☐

3. Were you born in one of the countries listed below? Yes ☐ No ☐

4. Have you traveled or lived for more than one month in any of the countries listed below? Yes ☐ No ☐

Health Care Provider:
If the student/patient answered “yes” to any of the above questions, Assumption requires you do a tuberculin skin test (Mantoux Test/Intermediate PPD) to check for latent tuberculosis infection – Section A.

If patient has had a Positive Tuberculin Skin Test in the past, the test should not be repeated. Go to Section B.

A. Secondary Screening: TUBERCULIN SKIN TEST (Mantoux/Intermediate PPD*)
*Result of multiple puncture tests (e.g., Tine or Monovac) is NOT accepted.

Plant date*: _____ / _____ / ______ Read date*: _____ / _____ / ______ Result* ______ mm of induration
* 48-72 hours after administration
* If no induration, mark "0"

B. Tertiary Screening: If Tuberculin Skin Test is POSITIVE (now, or by history) the following are required:

1. Date of Positive PPD: / / 

2. Chest X-ray: Normal ☐ Abnormal ☐ (attach report, NOT the X-ray) Date: / / 

Describe:

3. Clinical Evaluation: Normal ☐ Abnormal ☐

Describe:

4. Treatment: Yes ☐ No ☐ Drug, dose, frequency and dates:

Health Care Provider’s Name (Print)
Provider’s Signature Date

Address

Phone Number Fax Number