HARVARD UNIVERSITY
Health Services

75 Mount Auburn Street,
Cambridge, Massachusetts 02138

IMMUNIZATION HISTORY AY2024-2025
HEALTHCARE PROGRAMS

Last Name :

First Name :

Date of Birth : _____/_____/_____ **HUID** : _____

School : _____

Influenza Vaccination **This year's influenza vaccination must be completed after July 1, 2024. Vaccines before 7/1/2024 are not acceptable. Students have until mid-Fall 2024 to become compliant with this year's flu vaccine.** Recommend uploading to the Patient Portal as soon as received.	Date _____ MM/DD/YYYY One dose on or after July 1, 2024 (Harvard requirement)
Hepatitis B Immunization If series is complete, **a copy of the Hepatitus B surface antibody titer must be attached**, whether positive or negative. **Series incomplete (to be completed at HUHS):** #1_____ #2_____ MM/DD/YYYY MM/DD/YYYY	Series complete (dates) #1 _____ MM/DD/YYYY #2 _____ MM/DD/YYYY #3 _____ MM/DD/YYYY HBSAb titer date: _____ MM/DD/YYYY Result: HBSAb present HBSAb absent
Measles-Mumps-Rubella (MMR) A positive serological test for immunity to Measles, Mumps, and Rubella. A history of disease is not acceptable. **A copy of the laboratory report must be attached.** If available, record dates of immunizations. However, these will not substitute for the serology requirement.	**MMR #1** _____ MM/DD/YYYY **MMR #2** _____ MM/DD/YYYY **Measles #1**_____ MM/DD/YYYY **Measles #2** _____ MM/DD/YYYY **Rubella** _____ MM/DD/YYYY **Mumps** _____ MM/DD/YYYY
Meningococcal Vaccination **Required for students 21 years of age and younger.**	**Date** _____ MM/DD/YYYY **One dose after age 16** **Type: Menactra Menomune** **Other** _____

HARVARD UNIVERSITY
Health Services
75 Mount Auburn Street,
Cambridge, Massachusetts 02138

IMMUNIZATION HISTORY AY2024-2025
HEALTHCARE PROGRAMS

Polio (optional) It may be necessary in the future to need proof of your polio immunizations. You will find it convenient to have them listed here and may attach documentation of any other immunizations you may have received, such as Gardasil (HPV) and travel-related immunizations.	**Salk** _____ MM/DD/YYYY **Sabin** _____ MM/DD/YYYY
Tetanus/Diphtheria/Pertussis (Tdap) TD does not fulfill this requirement.	Tdap _____ MM/DD/YYYY **One dose within last 10 years (Harvard requirement)**
Tuberculosis Screening Since 4/1/2024 If IGRA blood test, a copy of the laboratory report must be attached. No new tuberculosis screening required if: • Prior skin test consistent with latent TB **OR** • Prior positive IGRA blood test **OR** • History of childhood BCG vaccination (date: _____) MM/DD/YYYY	Type and date of screening: _____ If PPD, #mm induration: _____ Negative Consistent with latent TB If consistent with latent TB, record date of chest Xray and attach report: _____ Record antibiotic therapy, if taken, and dates: _____ _____
Proof of Chickenpox (Varicella) Immunity **EITHER:** • A positive serological test for immunity **(please attach report)** **OR** • Documentation of vaccination	Positive Varicella titer date _____ MM/DD/YYYY **OR** Vaccination #1 _____ MM/DD/YYYY Vaccination #2 _____ MM/DD/YYYY

_____ _____

Signature and stamp of healthcare provider
PHYSICAL SIGNATURE & STAMP REQUIRED

Print name

_____ _____

Address/telephone number

Date