Harvard Summer Housing
2015 Immunization Form for Interns
Harvard Stem Cell Institute

In accordance with Massachusetts law, all interns living in Harvard housing must have proof of immunization on file with the University. Please fill out your name, date of birth, and sex, then give this form to your physician or university health services who will complete the rest. The completed form can be returned by email to maureen_herrmann@harvard.edu or by US Mail (HSCI, Attn: Maureen Herrmann, 7 Divinity Ave., Bauer Bldg. G11, Cambridge MA 02138).

PLEASE CLEARLY PRINT ALL INFORMATION

LEGAL NAME (must match exactly your passport or other government-issued identification)		
Last (family name)	First	Middle

DATE OF BIRTH (Example: DEC | 01 | 1990)	**SEX**
Month (MMM) Day(DD) Year (YYYY)	❑ Male ❑ Female

Required immunizations: Please record the date of immunizations, boosters, or tests. Please print clearly. **All information must be submitted in English.**

❑ This is the **first time** I am submitting this form this summer.

❑ I have **new information** to add to the form I submitted earlier this summer.
(Students: Please circle the information that is new. Do not resubmit this form unless you have new information.)

Measles–Mumps–Rubella (MMR). TWO immunizations on or after the first birthday, at least 1 month* apart, in 1967 or later (combined as MMR or separately)	First MMR: ____/____/_____ Second MMR: ____/____/_____ Month Day Year
If administered separately, record below:	
Measles (Rubeola). TWO immunizations as described above	First: ____/____/_____ Second: ____/____/_____ Month Day Year
German Measles (Rubella). TWO immunizations as described above	First: ____/____/_____ Second: ____/____/_____ Month Day Year
Mumps. TWO immunizations as described above	First: ____/____/_____ Second: ____/____/_____ Month Day Year

Exemption from MMR injection only if:
A positive serological test (titer) for immunity to any of the above diseases is acceptable instead of immunizations (a history of the disease is not acceptable):

Dates required: Pos MEASLES titer: ____/____/_____ Pos RUBELLA titer: ____/____/_____ Pos MUMPS titer: ____/____/_____
Month Day Year

OR, if born in the US before 1957, check here: ❑

Varicella (Chickenpox). TWO immunizations on or after the first birthday, at least 1 month* apart, on 01-MAR-1995 or later	First: ____/____/_____ Second: ____/____/_____ Month Day Year

Exemption from Varicella injection only if:
A positive serological test (titer) for immunity to Varicella or a certified history of the disease is acceptable instead of immunizations:

Dates required: Pos VARICELLA titer: ____/____/_____ OR Age at infection:_____ OR Date of disease: ____/____/_____
Month Day Year Month Day Year

OR, if born in the US before 1980, check here: ❑

Tetanus-Diphtheria-Pertussis. One dose of "Tdap" on 01-JAN-2005 or later. Vaccine must be Adacel, Boostrix, or ADULT acellular pertussis booster. No other vaccines can be accepted.	____/____/_____ Month Day Year

Hepatitis B. Three immunizations, the first and second of which must be at least 1 month* apart; the third must be at least two months* after the second and four months* after the first. If Twinrix, check here: ❑	First: ____/____/_____ Second: ____/____/_____ Third: ____/____/_____ Month Day Year
	OR Positive serological test Positive Hepatitis B antibody: ____/____/_____ Month Day Year

Meningococcal disease. Must be within the last 5 years. Students who will not live in Summer School housing may waive this requirement. To do so, the waiver form (available from the Summer School website) must be signed and submitted along with this form.	____/____/_____ month day year	❑ I will not live in Summer School housing and I am waiving the requirement for the Meningococcal vaccine. I have signed and attached the state waiver form.

* One month = 28 days

HEALTH-CARE PROVIDER OR MEDICAL RECORDS OFFICIAL		
Last/Family/Sur name(s)	First/Given name(s)	Middle name(s)
Address		Telephone number (including area/country code)

REQUIRED SIGNATURE OF HEALTH-CARE PROVIDER OR MEDICAL RECORDS OFFICIAL	**DATE** (must be on or after most recent vaccination/ test date)
	____/____/_____ month day year