SMITH COLLEGE

Last Name ____________ First Name ____________ Date of Birth ___/___/____ Smith ID# 99 ____________
MM DD YYYY

IMMUNIZATIONS

- **ALL students must comply with Massachusetts School Immunization Requirements.**
- **Include dates of administration in Month/Day/Year format.**
- **Your healthcare provider must submit a copy of your immunization records OR complete and sign this form.**
- **If titer blood test were performed as proof of immunity, copies must be submitted.**

Failure to meet all requirements by deadline will result in a hold on all student accounts

Most U.S. retail pharmacies and walk-in or urgent care clinics can provide and administer vaccines.

REQUIRED IMMUNIZATIONS: Include dates of administration in MM/DD/YYYY format	Date Dose 1	Date Dose 2	Date Dose 3	Date Dose 4	TITER: Date and Result *If performed, submit copy of written report*
Hepatitis B 3 doses (0, 1 month, 4-6 months) or positive titer (submit results)					
MMR: Measles, Mumps, Rubella **MMRV: Measles, Mumps, Rubella, Varicella** 2 doses of each or 2 doses of MMR or MMRV 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titers for each (submit results)					
Quadrivalent Meningitis (Students under age 22) (MenACWY/MCV4/Menactra/Menveo) 1 dose *after age 16*					N/A
Tdap (Adacel/Boostrix) 1 dose within 10 years					N/A
Varicella (Chicken Pox) 2 doses 1st dose *after 12 months of age* 2nd dose *at least 28 days after dose 1* or positive titer (submit results) or *physician-verified medical documentation of disease with date*					
Highly Recommended Immunizations					
DTP primary series					
Hepatitis A					N/A
HPV					
Meningitis B (Students under age 27) 2 doses of Bexsero					N/A
2 doses Trumenba					N/A
Polio primary series completed before age 4					N/A
Other Immunizations					
Japanese Encephalitis (Ixiaro)					N/A
Rabies					N/A
Typhoid (injectable)					
Typhoid (oral)					
Yellow Fever					
Other (i.e., flu)					

Your healthcare provider must submit a copy of your immunization records OR complete AND sign this form.

I HAVE REVIEWED THIS HISTORY WITH THE STUDENT AND ATTEST TO ITS ACCURACY.

Name of Provider ____________ **M.D./ D.O./ N.P./ P.A.** **Signature** ____________ **Date** ____________

Address ____________ City/Town ____________ State/County/Region ____________

Country ____________ Telephone ____________ Fax ____________

Submit a copy of your immunizations. Do not send original documents. Keep a copy for yourself.

Your healthcare provider's office can fax this form, test results, and a copy of your immunization records to 413-585-4639.

SMITH COLLEGE

Last Name ____________________ **First Name** ____________________ **Date of Birth** ___/___/_____ **Smith ID# 99** ____________
MM DD YYYY

TUBERCULOSIS (TB) RISK SCREENING: ***Date of screening or testing must be within past 3 months.***

In what country were you born? _________________________

Have you ever had a positive tuberculosis (TB) skin test?	☐ Yes	☐ No	Date__________
Have you ever had close contact with anyone who was sick with TB?	☐ Yes	☐ No	Date__________
Were you born in one of the countries listed below?	☐ Yes	☐ No	Date__________
Did you arrive in the U.S. within the past five years?	☐ Yes	☐ No	Date__________
Have you (or will you**) travel(ed) for more than two weeks to/in any country/ies listed below?	☐ Yes	☐ No	Date__________

Testing must be performed after any stay exceeding 14 days in any country listed below prior to arrival on campus.

CIRCLE any of the countries you traveled in or to within the past 5 years and include dates of travel.*

Afghanistan	Chad	Guinea-Bissau	Mali	South Africa
Angola	China	India	Republic of Moldova	Sudan
Armenia	Cote d'Ivoire	Indonesia	Mozambique Myanmar	Swaziland
Azerbaijan	Djibouti	Kazakhstan	Namibia	Tajikistan
Bangladesh	Haiti	Kenya	Nigeria	United Republic of Tanzania
Belarus	Hong Kong	Democratic People's Republic of Korea	Pakistan	Thailand
Botswana	Republic of the Congo	Kyrgyzstan	Papua New Guinea	Uganda
Bulgaria	Democratic Republic of the Congo	Latvia	Peru	Ukraine
Burkina Faso	Estonia	Lesotho	Philippines	Uzbekistan
Burundi	Ethiopia	Liberia	Russian Federation	Vietnam
Brazil	Ghana	Lithuania	Rwanda	Zambia
Cambodia	Georgia	Malawi	Sierra Leone	Zimbabwe
Cameroon			Somalia	
Central African Republic				

*If the answer to **ALL** questions above is **NO**, sign here. No further action is required.*

If the answer to ANY question above is YES:

Does the student have a past or current diagnosis of, or any symptoms of active tuberculosis? ☐ **Yes** ☐ **No**

If YES: Provide documentation of treatment dates, medications taken, sputum results and chest x-ray reports.

Blood Test Required: Interferon Gamma Release Assay (IGRA)—TSPOT or Quantiferon Gold

Date of blood test __________ Result: Negative ___ Positive ___ Intermediate ___ ☐ Submit copy of test results

If blood test is not available, a PPD skin test and/or chest x-ray can be performed as a temporary screening measure.
If IGRA is negative, no further action is required.

Chest x-ray required if blood test is positive OR indeterminate OR not available.

Provide full narrative copies of blood test reports AND chest x-ray reports, preferably in English.

Chest x-ray: Date of chest x-ray __________ **Result:** Normal ____ Abnormal _____ ☐ Submit copy of test results

ABNORMAL RESULTS require immediate medical evaluation. Contact our office promptly.

***If student travels to any country listed after date of initial screening—testing MUST be performed before arrival on campus.**

- *Students who mark YES to any question above and/or who have travelled/resided for more than 2 weeks in one of the countries listed must have TB TSPOT testing before arrival at Smith College.*
- *Failure to provide complete documentation AND copies of test reports will result in the inability to reside on campus, register for classes, or participate in college-related events.*
- ***Any person with abnormal results, symptoms of TB, OR being treated for TB must CONTACT OUR OFFICE BEFORE ARRIVAL and meet with the college physician immediately upon arrival at Smith College.***

I HAVE REVIEWED THIS FORM AND ATTEST THAT THE STUDENT IS AT LOW TO NO RISK FOR TUBERCULOSIS EXCEPT AS INDICATED ABOVE.

Name of Provider **M.D./ D.O./ N.P./ P.A.** **Signature** **Date**

Address City/Town State/County/Region

Country Telephone Fax

Your healthcare provider's office can fax this form, test results, and a copy of your immunization records to 413-585-4639.