To comply with state legislation (Chap. 76, Sec. 15C, General Laws of Mass.), BCC has adopted the following procedures on student immunizations:

**WHO MUST RESPOND?**

1. All full-time students (12 credits or more).
2. All students enrolled in any Health Science program (i.e., ADN, Health Science, LPN, PTA (Physical Therapist Assistant), Respiratory Care, Massage Therapy).
3. All foreign-born students.

**WHAT IS REQUIRED?**

1. One dose of Tdap if it has been longer than five years since the last dose of Td.
2. Two doses of MMR combination vaccine for Measles, Mumps and Rubella.
3. Three doses of Hepatitis B vaccine.
4. Two doses Varicella.
5. A recent negative Tuberculosis test (or negative chest x-ray within the last five years) for all foreign-born students upon entering BCC.
6. An annual Tuberculosis test for all Nursing and Allied Health program students (or one-time negative chest x-ray within the last five years).
7. History and physical report for Allied Health students only. See program requirements for additional health information and required form(s).

**WHAT PROOF IS NEEDED?**

1. The form on the back of this page can be filled out and signed by a medical professional; or
2. Other documentation from your physician/doctor’s office, your high school, military records, previous colleges, etc; or
3. Antibody laboratory blood test (Titer) indicating immunity for Measles, Mumps and Rubella (MMR), Varicella, and Hepatitis B must be accompanied by the laboratory report.

_In the event no documentation can be obtained, you must be re-immunized against these diseases. Contact your personal physician or community health services agency._
IMMUNIZATION HISTORY REQUIREMENT FORM REQUIRED FOR ALL STUDENTS WHO ARE FULL-TIME, OR ENROLLED IN AN ALLIED HEALTH PROGRAM OR ARE FOREIGN-BORN

Name

Please Print: ____________________________  First ____________________________  Middle Initial ____________________________

BCC ID# ____________________________  Date of Birth ___ / ___ / ________

Home Address ____________________________  Street ____________________________

City ____________________________  State    Zip ____________________________

Email Address ____________________________

Please mail or fax completed form to: Immunization Records Office, Berkshire Community College, 1350 West Street, Pittsfield, MA 01201-5786. Telephone: 413-236-1614 or Fax 413-499-4576.

-- Tdap VACCINE --
Tetanus/Diphtheria/ Pertussis

___ / ___ / ___
mm dd yy

or Td Tetanus Diphtheria within the last five (5) years

___ / ___ / ___
mm dd yy

-- MMR #1 --

___ / ___ / ___
mm dd yy

-- MMR #2 --

___ / ___ / ___
mm dd yy

-- HEPATITIS B --

#1

___ / ___ / ___
mm dd yy

#2

___ / ___ / ___
mm dd yy

#3

___ / ___ / ___
mm dd yy

Booster

___ / ___ / ___
mm dd yy

Titer**

___ / ___ / ___
mm dd yy

-- Medical Proof of Disease --

___ / ___ / ___
mm dd yy

-- Vaccine #1 --

___ / ___ / ___
mm dd yy

-- Vaccine #2 --

___ / ___ / ___
mm dd yy

-- Titer Immune** --

___ / ___ / ___
mm dd yy

**ANTIBODY LABORATORY BLOOD TESTS (TITER) MUST INCLUDE LABORATORY REPORT PROOF OF IMMUNITY.

REQUESTED, NOT REQUIRED, TO COMPLETE IMMUNIZATION HISTORY: MENINGOCOCCAL VACCINE ___ / ___ / ___

TUBERCULOSIS TEST

Date Planted

___ / ___ / ___
mm dd yy

Date Read

___ / ___ / ___
mm dd yy

Chest X-ray Date (If test is positive)

___ / ___ / ___
mm dd yy

Result ____________________________

If positive, treatment schedule ____________________________

REQUESTED, NOT REQUIRED, TO COMPLETE IMMUNIZATION HISTORY:

MEDICAL PROFESSIONAL’S SIGNATURE ____________________________  DATE ____________________________

MEDICAL PROFESSIONAL’S PRINTED NAME AND ADDRESS ____________________________

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