BERKSHIRE COMMUNITY COLLEGE

IMMUNIZATION REQUIREMENTS

IMPORTANT: Return completed form to Immunization Records Office (A-107) before the first day of classes or you may be withdrawn from the college.

To comply with state legislation (Massachusetts General Laws 105 CMR 220.600.), BCC has adopted the following procedures on student immunizations:

WHO MUST RESPOND?

1. All full-time students (12 credits or more) under the age of 30.*
2. All international 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 international students upon entering BCC.
6. Meningococcal vaccine required for students under 21 years of age. This vaccine may be waived after reading the Meningococcal Information and Waiver Form provided by BCC.

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.

* **Note:** The Massachusetts Department of Public Health (MDPH) has confirmed that the requirements for full-time students has changed starting in 2019-2020. Specifically, the immunization requirements will no longer apply to all full-time students, but only to those students who are "under 30 years of age." The immunization requirements for full and part-time health science students remain unchanged.

Berkshire Community College is an affirmative action/equal opportunity institution and does not discriminate on basis of race, creed, religion, color, gender, gender identity, sexual orientation, age, disability, genetic information, maternity leave, military service, or national origin in its education programs or employment.

(Please turn over)

IMMUNIZATION HISTORY REQUIREMENT FORM REQUIRED FOR ALL STUDENTS WHO ARE FULL-TIME OR ARE INTERNATIONAL

Name ____
Please print: Last First Middle Initial

BCC ID# ____________________ Date of Birth ____ /____ / ______

Home Address ____
Street

____
City State Zip

Email Address ____

Please mail or fax completed form to: Immunization Record Office, SBA Room A107, Student Engagement Center, 1350 West Street, Pittsfield, MA 01201. Phone: 413-236-1602 or Fax: 413-236-3098.

TDAP VACCINE

Tetanus/Diphtheria/Pertussis

____ /____ /____
mm dd yy

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

____ /____ /____
mm dd yy

MMR #1

____ /____ /____
mm dd yy

MMR #2

____ /____ /____
mm dd yy

TITER PROOF**

Measles

____ /____ /____
mm dd yy

Mumps

____ /____ /____
mm dd yy

Rubella

____ /____ /____
mm dd yy

HEPATITIS B

#1	#2	#3	Booster	Titer**
____ /____ /____	____ /____ /____	____ /____ /____	____ /____ /____	____ /____ /____
mm dd yy	mm dd yy	mm dd yy	mm dd yy	mm dd yy

VARICELLA (CHICKEN POX)

Medical Proof of Disease	Vaccine #1	Vaccine #2	Titer Immune**
____ /____ /____	____ /____ /____	____ /____ /____	____ /____ /____
mm dd yy	mm dd yy	mm dd yy	mm dd yy

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

MENINGOCOCCAL VACCINE (MenACWY)

For full-time students 21 years and younger, given at or after the student's 16th birthday

____ /____ /____
mm dd yy

Students can decline the MenACWY vaccine after they have read and signed the MDPH Meningococcal Information and Waiver Form sent with their acceptance letter, or available at the Immunization Records Office.

TUBERCULOSIS TEST*

Date Planted

____ /____ /____
mm dd yy

Date Read

____ /____ /____
mm dd yy

Result ______________________________

Chest X-Ray Date (If test is positive)

____ /____ /____
mm dd yy

Result ______________________________

If positive, treatment schedule ______________________________

***REQUIRED FOR ALL INTERNATIONAL STUDENTS.**

______________________________ ______________
Medical Professional's Signature **Date**

____
Medical Professional's Printed Name and Address

rev. 01/30/2020