Note to the Student:
Unless **ALL** required **Immunizations** are submitted you could be **administratively withdrawn** and a fee would be assessed for reinstatement.

IMPORTANT

Return this form to:

WSU Physician Assistant Program

577 Western Avenue

Westfield, MA 01086

Fax: 413-579-3301

PAstudies@westfield.ma.edu

TO BE FILLED OUT BY THE STUDENT

Please Print:

Name: Last | First | M.I. | Student ID# A | Date of Birth

Home Address: Street | City | State | Zip | Home Phone | Cell Phone

IMMUNIZATION VERIFICATION

All full-time students (9 or more graduate credits) must provide evidence of immunization. MA Law (Chapter 76-Section 15C). Copies of Immunizations from School Records or physicians' offices are acceptable.

TO BE FILLED OUT BY THE PHYSICIAN *or* Attach copy of electronic medical record/provider form

****Meningitis Vaccine required for full time undergraduate, residential students or signed meningitis information waiver form must be submitted.**

VACCINATIONS ✷ = ***Required***	DATE Month/Year	DATE Month/Year	DATE Month/Year	DATE Month/Year	DATE Month/Year
***Tdap (within the last 10 years)**	**#1.**	**#2.**	**#3.**	**#4.**	**#5.**
***MMR (2 doses required or Titers)**	**#1.**	**#2.**			
or *MMR titers Please circle results and note date	**#1.** Measles Titer (Rubeola) Pos Neg **Date:**	**#2.** Mumps Titer Pos Neg **Date:**	**#3.** Rubella Titer Pos Neg **Date:**		
***OPV / IPV (Oral or Intramuscular polio vaccine)**	**#1**	**#2**	**#3**	**#4**	
***Hepatitis B Series AND Surface Antibody Protective Titer**	**#1.**	**#2.**	**#3.**	**AND** Hepatitis Titer Pos Neg **Date:**	
***Varicella/VAR Series or Antibody Titer (2 vaccinations required or titer)**	**#1**	**#2**	**History of Chickenpox Date:**	**or** Varicella Titer: Pos Neg **Date:**	
****Menactra/Menveo/Menomune** Booster if no vaccination date after age 16 years	**#1.**	Meningitis B **Not required** Recommended for high risk individuals	**#1**	**#2** **Bexsero (2 dose series)**	**#3** **Trumenba (2 to 3 dose series)**
***Influenza (annually)**	**#1**				
COVID-19 Vaccination	**#1**	**#2**			
***PPD Mantoux Tuberculin Skin Test** (2 weeks apart) Or an IGRA-test (T-Spot or QuantiFERON Gold)	**#1. Date:** Neg ____mm	**#2. Date:** Neg ____mm	**Or** IGRA-test Pos Neg **Date:**		

I have examined the individual named above and to the best of my knowledge; he/she is in good physical and mental health, free of any communicable diseases and is able to function in his/her profession at full capacity.

Physician/Provider's Signature: ______________________________ **Date:** ______________

Address: ______________________________ **Printed Name:** ______________________________

City, State, Zip: ______________________________ **Phone:** ______________________________