291 Springfield Street • Chicopee, MA 01013-2839 • 413-594-2761 • www.elms.edu
Health Center • 413-265-2288 • 413-592-9939 (Fax) • healthcenter@elms.edu

# Immunization Form:

**To be completed by student:**

Please Print:

Last Name First Name M.I. Date of Birth

Home Address Street City State Zip Code

Home Phone Cell Phone Email Address

**To be completed by healthcare provider or attach copy of electronic medical record/provider form:**
**Elms College requires proof of all the following immunizations:**

**Chickenpox History**

☐ Check the box if this person has a physician-certified reliable history of chickenpox.

**Reliable history may be based on:**

- physician interpretation of parent/guardian description of chickenpox
- physical diagnosis of chickenpox, or
- serologic evidence of immunity

| | **Immunization Date(s) MM/DD/YYYY** | | | **Titer Results/ Date(s)** |
|---|---|---|---|---|
| Vaccine Name | Vaccine # 1 | Vaccine # 2 | Vaccine # 3 | |
| Tdap/Td | | | | |
| MMR | | | | |
| Measles | | | | |
| Mumps | | | | |
| Rubella | | | | |
| Hepatitis B | | | | |
| Meningococcal A | | | | |
| Varicella (Chicken Pox) | | | | |
| COVID-19 (Date and Brand) | | | | |
| Other | | | | |

**I certify that this immunization information was transferred from the above-named individual's medical records.**

Health Care Provider Name: _____ Date: _____

Address: _____

Phone: _____ Fax: _____

Signature: _____