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: _____