Registrar, Office of Student Services
1860 Washington Street, Newton, MA 02466
617-559-8642 Phone 617-559-8825 Fax
registrar@hebrewcollege.edu

2023-2024 IMMUNIZATION FORM

All matriculated students who will attend classes or programs on campus are required to provide proof of immunization. Students must be immunized against hepatitis B (three inoculations), measles, mumps and rubella (individually or through the MMR vaccine), tetanus and diphtheria (TDap vaccine), and varicella. Students must also be fully vaccinated against COVID-19 (depending on vaccine, one or two doses plus a booster).

Students may submit either the Hebrew College Immunization form, signed by a healthcare provider, or an immunization record which comes directly from the healthcare provider's office. This form needs to be submitted only once, before new students begin their studies, **and must be received before classes begin**.

Students who are medically exempt from vaccinations may submit a letter so stating signed by a health professional. Students who are not able to access their immunization records must review their situation with the director of their program at least 30 days before the beginning of the academic year, and may be asked to provide proof of immunity to the above diseases through blood tests.

Please return this completed form or another signed immunization record to:
Registrar's Office, Hebrew College, 1860 Washington Street, Newton, MA 02466
or Fax to 617-559-8825 **or** email to registrar@hebrewcollege.edu.

Name: _____ **Date of Birth:** _____

Program of Study: _____ **Year of Entry:** _____

Hepatitis B—3 doses are required

Hepatitis B (1st) _____ Hepatitis B (2nd) _____
Month/day/year Month/day/year

Hepatitis B (3rd) _____
Month/day/year

Measles, Mumps, Rubella—2 doses are required

MMR (1st) _____ MMR (2nd) _____
Month/day/year Month/day/year

Tetanus/Diphtheria (TDap)—1 dose required: must be within 10 years of today's date

Tdap _____
Month/day/year

Varicella—2 doses are required **OR** ☐ **Student had chicken pox** _____
Month/day/year

Varicella (1st dose) _____ Varicella (2nd dose) _____
Month/day/year Month/day/year

COVID-19 – 3 doses (Moderna, Pfizer) or 2 doses (Janssen, Johnson & Johnson) are required

COVID-19 (1st) _____ _____
Month/day/year Manufacturer

COVID-19 (2nd) _____ _____
Month/day/year Manufacturer

COVID-19 (3rd) _____ _____
Month/day/year Manufacturer

Healthcare Provider Information

Name: _____

Address: _____

Phone Number: _____

Signature: _____

Date: _____