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

2024-2025 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

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: ____