



Note to the Student: Unless **ALL** required **Immunizations** are submitted you could be **administratively withdrawn** and a fee would be assessed for reinstatement.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

VACCINATIONS * = <u>Required</u>	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	

**Westfield State University Physician Assistant Program
Immunization Verification Form**

Student: _____ **DOB:** _____

*Hepatitis B Series <u>AND</u> Surface Antibody Protective Titer	#1.	#2.	#3.	<u>AND</u> Hepatitis Titer Pos Neg Date:	
*Varicella/VAR Series <u>AND</u> Antibody Titer (2 vaccinations required or titer)	#1	#2	History of Chickenpox Date:	<u>AND</u> 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 Manufacturer:	#2 Manufacturer:	Booster(s): Manufacturer:	Manufacturer:	Manufacturer:
*QuantiFERON Gold (within the last 12 months)	Pos Neg Date:				

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

I have examined the individual named above and to the best of my knowledge; they are in good physical and mental health, free of any communicable diseases and is able to function in their graduate education activities at full capacity.

Physician/Provider's Signature: _____ **Date:** _____

Printed Name: _____

Address: _____

City, State, Zip: _____

Phone: _____