The MacDuffie School

CERTIFICATION of IMMUNIZATION

Per Massachusetts regulation 105 CMR 220.00, ALL students **MUST be compliant with ALL Massachusetts required immunizations prior to school attendance

STUDENT NAME:_____ DOB(m/d/y):_____

Please **circle the specific type of vaccination where indicated

REQUIRED VACCINE	**Dose 1**	**Dose 2**	**Dose 3**	**Dose 4**	**Dose 5**
DTP / DTap (4 doses required, 4th dose after age 4)					
Tdap (1 dose required after age 7)					
Polio - tOPV / bOPV / mOPV / IPV (4 doses required, 4th dose after age 4)					
Meningococcal - Conjugate (2 doses required, 2nd dose after age 16)					
MMR / MMRV (2 doses required after age 1)					
Hepatitis B - (3 doses required)					
Varicella (2 doses required after age 1)			**History of varicella disease, please write date of disease here:**_____		
NON-REQUIRED VACCINE	*The following vaccines are not required, but recommended.*				
Hepatitis A					
Meningococcal- Serogroup B					
Human Papillomavirus (HPV)					
Pneumococcal Conjugate					
BCG					
Yellow Fever					
Covid-19 (manufacturer:_____)					

Physician's Printed Name: _____

Physician's Signature:(REQUIRED) _____ Date: _____