HARVARD UNIVERSITY
Health Services

75 Mount Auburn Street,
Cambridge, Massachusetts 02138

IMMUNIZATION HISTORY AY2026-2027

CLINICAL HEALTHCARE PROGRAMS

Last Name :

First Name :

Date of Birth : _____/_____/_____ **HUID** : _____

School : _____

Influenza Vaccination This year's influenza vaccination must be completed after 7/1/2026. Vaccines before 7/1/2026 are not acceptable. Students have until late September 2026 to meet the flu vaccine requirement. **Flu vaccine is not needed for Summer 2026 or Fall 2026 registration.** Recommend uploading to the Patient Portal as soon as received.	Date _____ MM/DD/YYYY One dose on or after 7/1/2026 (Harvard requirement)
Hepatitis B Immunization If series is complete, **a copy of the Hepatitus B surface antibody titer must be attached**, whether positive or negative. **Series incomplete (to be completed at HUHS):** #1_____ #2_____ MM/DD/YYYY MM/DD/YYYY	Series complete (dates) #1 _____ MM/DD/YYYY #2 _____ MM/DD/YYYY #3 _____ MM/DD/YYYY HBSAb titer date: _____ MM/DD/YYYY Result: HBSAb present HBSAb absent
Measles-Mumps-Rubella (MMR) A positive serological test for immunity to Measles, Mumps, and Rubella. A history of disease is not acceptable. **A copy of the laboratory report must be attached.** If available, record dates of immunizations. However, these will not substitute for the serology requirement.	**MMR #1** _____ MM/DD/YYYY **MMR #2** _____ MM/DD/YYYY **Measles #1**_____ MM/DD/YYYY **Measles #2** _____ MM/DD/YYYY **Rubella** _____ MM/DD/YYYY **Mumps** _____ MM/DD/YYYY
Meningococcal Vaccination **Required for students 21 years of age and younger.**	**Date** _____ MM/DD/YYYY **One dose after age 16** **Type: Menactra Menomune** **Other** _____

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Polio (optional) It may be necessary in the future to need proof of your polio immunizations. You will find it convenient to have them listed here and may attach documentation of any other immunizations you may have received, such as Gardasil (HPV) and travel-related immunizations.	**Salk** _____ MM/DD/YYYY **Sabin** _____ MM/DD/YYYY
Tetanus/Diphtheria/Pertussis (Tdap) TD does not fulfill this requirement.	Tdap _____ MM/DD/YYYY **One dose within last 10 years (Harvard requirement)**
Tuberculosis Screening Since 4/1/2026 If IGRA blood test, a copy of the laboratory report must be attached. No new tuberculosis screening required if: • Prior skin test consistent with latent TB **OR** • Prior positive IGRA blood test **OR** • History of childhood BCG vaccination (date: _____) MM/DD/YYYY	Type and date of screening: _____ If PPD, #mm induration: _____ Negative Consistent with latent TB If consistent with latent TB, record date of chest Xray and attach report: _____ Record antibiotic therapy, if taken, and dates: _____ _____
Proof of Chickenpox (Varicella) Immunity **EITHER:** • A positive serological test for immunity **(please attach report)** **OR** • Documentation of vaccination	Positive Varicella titer date _____ MM/DD/YYYY **OR** Vaccination #1 _____ MM/DD/YYYY Vaccination #2 _____ MM/DD/YYYY

- The Immunization History Form is to be completed by your healthcare provider. Your healthcare provider must sign, date, and provide their professional signature stamp attesting to the vaccine documentation provided. You may then upload the document to the **Patient Portal**.
- If you do not have a healthcare provider who can complete and sign this form, you may instead upload your original vaccine documentation from the hospital, provider's office, or any place where you received your vaccines. All documentation must be in English and uploaded to the **Patient Portal.**
- If you received any of your immunizations in the United States, you may also use the Immunization Registry for the state in which they were given. Through this registry, you may obtain your official vaccination record, which you can then upload to the **Patient Portal**.

_____

Signature and stamp of healthcare provider
PHYSICAL SIGNATURE & STAMP REQUIRED

_____

Print name

_____

Address/telephone number

_____

Date