Westfield STATE UNIVERSITY
PHYSICIAN ASSISTANT STUDIES

Note to the Student: Unless **ALL** required **Immunizations** are submitted you could be **administratively withdrawn** and a fee would be assessed for reinstatement.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 ✸ = ***Required***	**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 AND Surface Antibody Protective Titer**	**#1.**	**#2.**	**#3.**	**AND** Hepatitis Titer Pos Neg **Date:**	
***Varicella/VAR Series AND Antibody Titer (2 vaccinations required or titer)**	**#1**	**#2**	**History of Chickenpox Date:**	**AND** 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:_____