

Immunizations

Cushing Academy Admissions Office tel: (978) 827-7300
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To be completed by primary care physician

The following immunizations are **required** for attendance at school in the Commonwealth of Massachusetts.

These are not optional.

Student's Name: _____ Date of Birth: _____
FIRST MIDDLE LAST MONTH/ DAY/ YEAR

Please enter immunization dates (month and year)

DTP: #1 _____ #2 _____ #3 _____ #4 _____ #5 _____
Polio: #1 _____ #2 _____ #3 _____ #4 _____
Td: (every 10 years) #1 _____
Measles: (2 doses) #1 _____ #2 _____ (proof of blood titre required if records are unavailable) _____
Mumps: #1 _____
Rubella: #1 _____
Hepatitis B: #1 _____ #2 _____ #3 _____
Varicella vaccine: #1 _____ #2 _____ or Date of Illness: _____
MONTH/ YEAR
Meningoccal: #1 _____
Gardasil: (optional) #1 _____ #2 _____ #3 _____

Tuberculin test - PPD within one year prior to entrance (regardless of bcg)

Tb skin test (ppd): Date: _____ Results: _____ mm induration
If positive skin test: chest xray required: Date: _____ Results: _____
Medication: _____ Date started: _____ Duration: _____
Has the student received BCG? Yes No Date: _____
MONTH /YEAR

Physician's information

Physician's Name: _____
FIRST MIDDLE LAST TITLE
Address: _____
STREET

CITY STATE COUNTRY
Phone: _____ Fax: _____
Physician's Signature: _____ Date: _____