COLBY COLLEGE
4460 Mayflower Hill
Waterville, Maine 04901
TEL 207-859-4460
FAX 207-859-4475
healthservices@colby.edu

Immunization Form

Please Return by July 15

To maintain the health and safety of the campus community and comply with state laws, Colby requires a verified record of immunizations for every student. This two-page form must be completed and signed by a healthcare provider and returned to Colby by July 15.

Last Name:	**First:**	**M:**	**Date of Birth:**

REQUIRED VACCINES		
	Dates Given (Month/Day/Year)	**Maine State Requirements**
MMR	**#1** ___/___/_____ **#2** ___/___/_____ **OR** Positive Titer Date : ___/___/_____	2 doses, with first dose given after 1st Birthday
Measles	**#1** ___/___/_____ **#2** ___/___/_____ **OR** Positive Titer Date : ___/___/_____	Minimum of 4 weeks between doses
Mumps	**#1** ___/___/_____ **#2** ___/___/_____ **OR** Positive Titer Date : ___/___/_____	May have combined MMR or individual vaccines
Rubella	**#1** ___/___/_____ **#2** ___/___/_____ **OR** Positive Titer Date : ___/___/_____	
Meningococcal Quadrivalent (A, C, W, Y)	Menactra ___/___/_____ Menveo ____/____/____ MedQuadfi ____/____/____	One dose given at age 16 or older for all incoming students
Tdap* or TD	Tdap ___/___/_____ or Td ___/___/_____	1 Tdap*/Td Booster within the last 10 years (* preferred)

Maine State Law 10-144 requires that any student enrolled in post-secondary education have received 2 MMR vaccines after their first birthday (or show immunity from titer testing) and have received a TDaP/TD vaccine within 10 years of enrollment. The Meningococcal Quadrivalent (ACWY) is required by Colby College. No religious or philosophical exemptions are allowed for these. If the student has a medical exemption for these vaccines, a letter will need to be submitted from a physician (MD or DO), nurse practitioner (NP), or physician assistant (PA) who is not related to the student. A sample form can be found here. Please contact the Colby Health Center at healthservices@colby.edu or 207-859-4460 with any questions.

Immunization Form Please Return by July 15

Last Name:	First:	M:	Date of Birth:

RECOMMENDED VACCINES

	Dates Given (Month/Day/Year)
Serogroup B Meningococcal	Bexero **#1**____/____/____ **#2** ____/____/____ Trumenba **#1**____/____/____ **#2** ____/____/____ if given **#3** ____/____/____
Hepatitis A	**#1** ___/___/_____ **#2** ___/___/_____
Hepatitis B	**#1** ___/___/_____ **#2** ___/___/_____ **#3** ___/___/_____ **OR** Positive Titer Date : ___/___/_____
Varicella (Chicken Pox)	**#1** ___/___/_____ **#2** ___/___/_____ **OR** Positive Titer Date : ___/___/_____ History of Disease: ☐ YES date: _____ ☐ NO
HPV (Gardisil)	**#1** ___/___/_____ **#2** ___/___/_____ **#3** ___/___/____
Hib	Most recent booster: ___/___/_____
Polio	Primary Series: ☐ Oral ☐ Injectable Most recent booster: ___/___/_____
COVID-19 While not required, the COVID-19 vaccine is highly recommended for all students, faculty and staff	Moderna #1_____ #2_____ Booster: _____ Pfizer #1_____ #2 _____ Booster: _____ Johnson and Johnson/Jenssen #1_____ Other _____

For International Students ONLY

History of a positive TB skin test or IGRA blood test? ☐ YES - Date ___/___/____ ☐ NO *if yes, please provide documentation
Chest Xray Date ___/___/_____ Results _____ *if yes, please provide documentation ☐ N/A
History of BCG vaccination? ☐ YES - Date ___/___/_____ ☐ NO *if yes, please provide documentation *Consider doing IGRA

Tuberculin Skin Test
Date Given ___/___/_____ Date Read ____/____/____
Result: _____mm of induration **Interpretation: positive _____ negative_____
IGRA
Date Obtained:____ /____ /____ (specify method) QFT-GIT_____ T-Spot _____other_____
Result: _____

Physician's Signature _____ Date: _____
Printed Name _____ Tel: _____
Address _____ Fax: _____