



Tufts Summer Study  
Dowling Hall  
419 Boston Avenue  
Medford, MA 02155  
617-627-2000 phone  
617-627-4691 fax

## *Medical Director's Letter*

Name of Student \_\_\_\_\_

April/May/June 2012

Dear Physician:

Your patient plans to enter Tufts University to participate in a summer program. The following immunizations are required for visiting summer students. We request that you review them and insure that your patient is adequately immunized.

Please fill in the immunization form on the reverse side of this letter and return it to the student. The student must send the form to the Tufts Summer Study Office

### **Immunizations:**

- **Measles, Mumps, Rubella:** Immunity to these diseases must be documented by immunization with the live vaccine or by serological (antibody) titers. History of having had the disease will not be acceptable for documentation of immunity. Two injections of measles and mumps vaccine are required, given at least one month apart, with the first given at 12 months of age or after. If the injections were administered before 12 months of age or before 1968, two more injections will be required. The MMR vaccine is recommended.
- **Varicella Vaccine:** Two doses of varicella vaccine, or history of the illness, must be documented. If immunized at age 13 or greater, the two injections must be at least one month apart.

Thank you for your help with this summer student at Tufts University.

Sincerely yours,

Margaret Higham, M.D.  
Medical Director



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# Immunization Record

Name of Student \_\_\_\_\_

Student Date of Birth \_\_\_\_\_

## Student Immunization Record

Meningococcal Vaccine: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

MMR Dose #1 (given on or after 12 months of age): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

MMR Dose #2 (given at least four weeks after first dose): \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

Varicella Dose #1: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

Varicella Dose #2: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
mm/dd/yy

**OR**

	Actual Results of Antibody Titers	Dates
Measles:		
Mumps:		
Rubella:		
Varicella:		

## Physician Information

Name \_\_\_\_\_

Physician's Phone Number \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_