NORTHEASTERN UNIVERSITY

HEALTH REQUIREMENTS

Northeastern
University Health & Counseling Services

Dear Northeastern University Student:

Welcome to the university. All students are required to upload their vaccination documentation. Students who entered Northeastern in the fall of 2024, please see the directions for Sentry MD.

This packet includes a complete list of all required and recommended immunizations and instructions for fulfilling these requirements. Please read the following directions carefully. Any student failing to provide the required immunization documentation will be prohibited from registering and attending all classes.

STEP 1: GATHER THE REQUIRED HEALTH DOCUMENTS

- Begin by reviewing each vaccine, test, and document requirement listed on the following page of this Health Requirement Packet. You must review this material carefully and have your healthcare provider sign and date the required forms below.

  Part II Required Immunization Record (to be completed by the healthcare provider)

  Part III TB Risk Assessment form (to be completed by the student)

  Part V Recommended Immunizations (to be completed by the healthcare provide)

WE HOPE THESE TOOLS HELP YOU STAY ON TOP OF YOUR STATUS AND KEEP YOU COMPLIANT.

QUESTIONS

If you have any questions regarding Northeastern's immunization requirements or the contents of this packet, please email us at immunizations@northeastern.edu Email inquiries will be responded to within 48 business hours.

FOR MORE INFORMATION

Visit Documentation of Immunity - University Health and Counseling Services for more information about required and recommended vaccines.

DEADLINES TO UPLOAD IMMUNIZATION REQUIREMENTS:

JULY 15, 2025 for **UNDERGRADUATE STUDENTS** entering the University in Fall 2025.

DECEMBER 31, 2024 for **UNDERGRADUATE STUDENTS** entering the University in Spring 2025.

GRADUATE STUDENTS must upload no later than one month before entering the University.

NORTHEASTERN UNIVERSITY

HEALTH REQUIREMENTS

Northeastern University Health & Counseling Services

PART I: REQUIRED STUDENT IMMUNIZATION RECORD

This state-mandated immunization form must be completed by your healthcare provider. If preferred, you can submit an official electronic printout of your immunization record signed by the provider or the clinic or provider's form with their signature and/or letterhead. **To be accepted, all documentation must be provided in English using the preferred date format of MM/DD/YYYY. (M = Month, D = Day, Y = Year)**

Tetanus Diphtheria, Pertussis (Tdap): Tdap vaccine within 10 years of the current date OR history of a Tdap vaccine and a TD booster within 10 years of the current date. Dtap vaccinations are NOT accepted

Tdap Vaccine Date ____/__/____	**OR**	TD booster (Tdap must be documented) Date ___/___/___

Hepatitis B: 3-dose vaccine series, **OR** Heplisav-B 2-dose vaccine series, **OR** Positive Hep B Surface Antibody Serology.

Hep B 3-Dose Series 1) ___/___/____ 2) ___/___/____ 3) ___/___/____	**OR**	Heplisav-B 2 -Dose Series 1) ___/__/____ 2) ___/___/____	**OR**	Hep B Surface Antibody Serology ___/___/____ Result: □Immune □ Non-Immune

Meningococcal ACWY (Meningitis): 1-dose of MenACWY vaccine dated after age 16 **OR** complete the Meningococcal Waiver. Anyone 21 years of age or older is auto-exempt from this requirement. Men B vaccines do NOT meet the requirement

Menactra Vaccine ___/___/___	**OR**	Menveo Vaccine ___/___/___

Measles, Mumps, and Rubella (MMR): 2-dose vaccine series with both doses administered after 12 months of age and at least 28 days apart, **OR** Positive antibody titers for Mumps, Measles, and Rubella. If you have an MMR vaccine prior to 12 months of age, you need a 3rd MMR dose.

MMR 2-Dose Series Dates 1). ___/___/____ 2). ___/___/____	**OR**	Measles 1.) ___/___/____ 2.) ___/___/____ Mumps 1.) ___/___/____ 2.) ___/___/____ Rubella 1.) ___/___/____ 2.) ___/___/____	**OR**	Measles Titer Date __/__/____ Result: □Immune □ Non-Immune Mumps Titer Date __/__/____ Result: □Immune □ Non-Immune Rubella Titer Date __/__/____ Result: □Immune □ Non-Immune

Varicella (Chicken Pox): 2-dose vaccine series administered at least 28 days apart **OR** Positive antibody titer **OR** History of illness.

Varicella 2-Dose Series 1) ___/___/____ 2) ___/___/____	**OR**	Varicella Titer ___/___/____ Result: □Immune □ Non-Immune	**OR**	Date of chickenpox disease ____/____ *Month and Year required*

HEALTHCARE PROVIDER'S SIGNATURE IS REQUIRED FOR IMMUNIZATIONS ON THIS FORM TO BE ACCEPTED

Provider's Signature (Required) ______________________________ **Date** ____/____ /_____

Provider Name (printed) ______________________________ *Provider's Stamp if Available*

Address ______________________________

Phone Number (____) ____________________

Student Name ______________________________ NUID ______________________________

PART II: REQUIRED TB RISK ASSESSMENT

To be completed by the student.

TUBERCULOSIS (TB) RISK ASSESSMENT

If any of the following apply to you, please check the appropriate risk factor box and complete the TB test portion in Grey, OR if none of these apply to you check the last box- No TB risk factors and you do not need to complete the grey portion.

☐ **Birth, travel, or residence for at least 1 month, or frequent border crossing in a country with an elevated TB rate.**

- Includes any country other than the United States, Canada, Australia, New Zealand, or a country in western or northern Europe.
- Interferon Gamma Release Assay (IGRA) is preferred over Tuberculin Skin Test (TST) for foreign-born persons >2 years old. The TST is an acceptable test for all ages when administered and read correctly.

☐ **Immunosuppression**, current or planned

- HIV infection, organ transplant recipient; treated with TNF-alpha antagonist (e.g., infliximab, etanercept, others), steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication

☐ **Close contact** to someone sick with infectious TB disease since last TB Risk Assessment

If ANY of 3 boxes above are checked:

Please contact your healthcare provider for additional testing outlined below and their required signature.

- Latent TB infection testing is required.

TB Skin Plant **Date**: __/__/__ **OR** **TB Skin Read** **Date**: __/__/__ **Result** _____ **mm** ☐ **Neg** ☐ **Pos**	**QuantiFERON TB Gold** **Date**: __/__/__ ☐ **Neg** ☐ **Pos**

- If latent TB is positive, please complete a chest x-ray and TB Symptom Questionnaire. If latent TB infection test result is positive and active TB disease is ruled out, treatment of latent TB infection is recommended.

IF positive TB test: **Chest X-ray: ___/___/____ AND** **Complete the TB Symptom Questionnaire** Positive TB Symptom Questionnaire**.**

- Students are required to REPORT Latent TB Infection and Active or Suspected Active TB Disease Go to www.mass.gov/tuberculosis

Provider's Signature (required)________________________________ **Date** ____/____ /_____

Provider Name (printed) ___________________________________

☐ **No TB risk factors**. TB test not indicated; no TB test done

Student Name ____ **Student Date of Birth** ____/____ /_____ **Date of completing this form** ___/____/______

*See the Massachusetts Tuberculosis Risk Assessment User Guide for more information about using this tool. Massachusetts Department of Public Health | Bureau of Infectious Disease and Laboratory Sciences | Division of Global Populations and Infectious Disease Prevention | www.mass.gov/tuberculosis | Adapted from the California Tuberculosis Risk Assessment see www.ctca.org August 2024

Northeastern University Health & Counseling Services

PART III: RECOMMENDED STUDENT IMMUNIZATION RECORD

To be completed by your primary care physician. **To be accepted, all documentation must be provided in English using the preferred date format of MM/DD/YYYY. (M = Month, D = Day, Y = Year)**

Influenza (Flu): Seasonal Flu Vaccine (Administered in August- March of the current year).

Flu Vaccine: ____/____/_____

Hepatitis A: 2-dose vaccine series administered at least 6 months apart, **OR** Positive antibody titer.

Hepatitis A Series:
1) ___/___/____ 2) ___/___/____

Meningitis B Series: 2-dose Bexsero vaccine series, **OR** 3-dose Trumenba vaccine series. Note, these do not meet the required MenACWY vaccine.

Bexsero 2-Dose Series:	**OR**	**Trumenba 3-Dose Series:**
1) ___/___/____ 2) ___/___/____		1) ___/___/____ 2) ___/___/____ 3) ___/___/____

COVID-19 Vaccines: Initial series of COVID-19, **OR** booster doses.

Primary Series:	**OR**	**Bivalent Dose:**	**OR**	**Seasonal Dose:**
1) ___/___/____ 2) ___/___/____ Manufacturer Name:		___/____/____		___/____/____

HPV: 2-dose vaccine series if administered prior to age 15. If the 2nd dose is administered prior to 6 months from the 1st dose, a 3rd dose should be administered.

HPV Vaccine Series:
1) __/__/____ 2) __/__/____ 3)__/__/____

HEALTHCARE PROVIDER'S SIGNATURE IS REQUIRED FOR IMMUNIZATIONS ON THIS FORM TO BE ACCEPTED

Provider's Signature ____ **Date** ____/____/_____ *Provider's Stamp if Available*

Provider Name (printed) ____________________________________

Address ____

Phone Number (____) ______________________

Student Name ____ NUID __________________________________

PART IV: REQUIRED CONSENT FOR TREATMENT

To be completed by the student or guardian.

CONSENT FOR STUDENTS 18 YEARS OF AGE AND OLDER

I give Northeastern University or Authorized Representative permission to provide such medical or mental healthcare while I am a student at the University, including examinations, treatments, immunizations, etc. This also includes referral to outside providers, a local hospital and/or hospitalization, anesthesia, or surgery should it be necessary in the event of an emergency.

There is no cost for visits at UHCS (Boston) or CAPS (Oakland). I understand that I may be charged for lab tests, imaging, prescriptions, specialist, and acute care visits. It is my responsibility to refer to my health insurance plan information for coverage of medical and mental health services.

Student Name ______________________________ NUID ______________________________

Signature ______________________________ DATE ______________________________

CONSENT FOR STUDENTS UNDER 18 YEARS OF AGE

Signature of parent/guardian is required if student is under 18 years of age and is valid until student turns age 18.

I hereby grant permission for Northeastern University or Authorized Representative to provide such medical or mental health care as my child ______________________________ (STUDENT NAME) may require while they are a student at Northeastern University, including examinations, treatments, immunizations, etc. This also includes referral to outside providers, a local hospital and/or hospitalization, anesthesia, or surgery should it be necessary in the event of an emergency.

Student Name ______________________________ NUID ______________________________

Signature ______________________________ DATE ______________________________

Parent / Guardian ______________________________ DATE ______________________________

Signature ______________________________ RELATIONSHIP ______________________________

STUDENT CHECKLIST

This checklist will help you organize what is needed for submission and ensure that you have completed all steps appropriately. Please allow yourself plenty of time to review your requirements in case you need additional vaccines or tests. Once uploaded, your documents will be processed in 24 to 72 business hours. You will receive a confirmation email once your documents have been reviewed and verified.

- ☐ Health Requirements are complete, and results are signed, dated, and stamped by your healthcare provider, or supplemental documents on your provider or clinic's form to meet each requirement.

PART I: REQUIRED IMMUNIZATION RECORD (PAGE 2)

- ○ Tdap vaccine within 10 years
- ○ HepB 3-dose series or Heplisav-B series or titer
- ○ MenACWY dose after 16 or signed waiver
  - ☐ To access the Meningitis waiver, go to Meningococcal Waiver.
- ○ MMR 2-dose series or titer
- ○ Varicella 2-dose series, proof of disease, or titer
- ○ Provider has signed and dated the form

PART II: TB RISK ASSESSMENT FORM (PAGE 3)

- ○ TB Risk Assessment Form is completed.
  - ☐ TB Risk assessment has the student's name, assessment date, and date of birth along with a checkbox indicating your answer marked MA TB Risk Assessment Form.
    - ☐ If you check any of the 3 boxes, please submit a TB test with signature.
    - ☐ If your TB test is positive, submit a recent chest X-ray result (dated after the positive TB test) and Positive TB, Symptom Questionnaire.

PART III: RECOMMENDED IMMUNIZATION RECORD (PAGE 4)

PART IV: CONSENT TO TREAT (PAGE 5)

- ○ Sign the student consent to treat
  - ☐ Signature of parent/guardian is required if student is under 18 years of age.

- ☐ Submit completed documents to immunizations@northeastern.edu

QUESTIONS

If you have any questions regarding immunization requirements or the contents of this packet, please email us at immunizations@northeastern.edu. Email inquiries will be responded to within 48 business hours.