



**CITY OF NEWTON, MASSACHUSETTS**  
 Department of Planning and Development  
 Candace Haven, Interim Manager

Ruthanne Fuller  
 Mayor

Telephone  
 (617) 796-1120  
 Telefax  
 (617) 796-1142  
 E-mail  
 Barney Heath,  
 Director

**ESP Immunization Record –Staff Over the Age of 18**

In accordance with state regulation, ESP will maintain an immunization record for each staff members who are over the age of 18.

**Required Immunizations**

All students and full time staff members under the age of 18 must supply the following written documentation of immunization or alternate proof of immunity:

1. Measles, Mumps, and Rubella (MMR) Vaccine. At least one dose of MMR vaccine(s) at or after 12 months of age or there must be proof of laboratory evidence of immunity;
2. Polio Vaccine: At least three doses of either trivalent oral polio vaccine (OPV) or enhanced potency inactivated polio vaccine (e-IPV) are required. If a mixed schedule of polio vaccine is given (IVP and OPV), a total of four doses is required;
3. Diphtheria and Tetanus Toxoids and Pertussis Vaccine: At least four doses of DTaP/DTP/DT/Td are required. (The Pertussis component is not given to anyone seven years of age or older). A booster dose of tetanus/diphtheria, adult-type toxoid (Td) is required if more than ten years have elapsed since the last dose;
4. Hepatitis B: For anyone born on or after January 1, 1992 three doses of Hepatitis B vaccine are required.

Staff Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

Home Tel. Number: \_\_\_\_\_

Name(s) of Student's/Staff's Parent(s)  
 or Guardians: \_\_\_\_\_

Address of Student's/Staff's Parent(s)  
 or Guardians: \_\_\_\_\_

Tel. No. of Student's/Staff's Parent(s)  
 or Guardians: \_\_\_\_\_

Staff's Date of Birth: \_\_\_\_\_

Itemized List of Immunizations in Accordance with Requirements:




9. Are you taking any medication? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes

NAME OF MEDICATION \_\_\_\_\_

REASON \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DOSAGE \_\_\_\_\_

TIME/S AND HOW TO BE TAKEN \_\_\_\_\_

10. Do you have a history of allergies? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

11. Are you allergic to bees? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, to what extent? \_\_\_\_\_

\_\_\_\_\_

12. Have you had any recurring knee, foot, or ankle problems, or any injury to his/her muscles, joints or bones during the past year? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain. \_\_\_\_\_

\_\_\_\_\_

13. Please notify us if you have any other problems we should be aware of, such as phobias, car sickness, bedwetting, bronchitis, sleepwalking, nightmares, etc.