

IMMUNIZATION RECORD

Last Name	First Name	Middle Name	Date of Birth	Student ID#
Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. Student to confirm identifying information above is complete before submission.				

SECTION A Required Immunizations	mo/day/year	mo/day/year	mo/day/year	mo/day/year	SUBMIT LABORATORY REPORT
* DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)	
*Tdap booster (If due update after 7/2008)					
* Td booster					
* Polio					
* MMR (after first birthday)					
* Measles/ Rubella (MR) (after first birthday)					
* Measles (after first birthday)			** Disease Date	Titer Date & Result	
* Mumps			Not Acceptable *** Disease Date	Titer Date & Result	
* Rubella			Not Acceptable *** Disease Date	Titer Date & Result	
* Hepatitis B (Required if born 7/1/94 or after)	(#1)	(#2)	(#3)		

SECTION B Recommended Immunizations

The following immunizations are recommended for all students and may be required by certain colleges or departments (for example, health sciences). Please consult your college or department materials for specific requirements.

Meningococcal vaccine: No () Yes () Which vaccine? Menactra () Menomune () Date given:

	mo/day/year	mo/day/year	mo/day/year	mo/day/year
* Hepatitis B series only				****anti-HBs Date & Result
* Hepatitis A/B combination series				
*Varicella (chicken pox) series of two doses or immunity by positive blood titer			Disease Date	****Titer Date & Result
* Tuberculin Skin Test (PPD) Date read (within 12 months) Report result in mm induration				
Chest X-Ray, if positive PPD Date Results				
Treatment if applicable Date				

SECTION C Optional Immunizations

	mo/day/year	mo/day/year	mo/day/year
* Haemophilus influenzae type b			
* Pneumococcal			
* Hepatitis A series only			
* HPV (Gardasil)			
* Other			

Signature or Clinic Stamp REQUIRED:

Signature of Physician/Physician Assistant/Nurse Practitioner	Date		
Print Name of Physician/Physician Assistant/Nurse Practitioner	Phone number		
Office Address	City	State	Zip Code

** Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History of physician-diagnosed measles disease is acceptable, but must have signed statement from physician.

*** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

**** Lab Report must be submitted.