## 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 |
|---|---|---|---|---|
| * 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) | |

SUBMIT LABORATORY REPORT

## 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 |
| OR | | | | |
| * 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.

FORM UPDATED 11/2009