# Immunization Record

Student's Name: ___________________________________________ Birth date: ____/____/______
(last) (first)

Bronc ID ________________________ Starting Term ☐ Fall ☐ Spring Year _________

Full Time Student? (12 credits or more) ☐ Yes ☐ No

I will reside on campus: ☐ Yes ☐ No

**To be completed and signed by a Health Care Provider. If more convenient, you may attach a copy of your immunization records. A copy of laboratory reports must be attached for all blood titers.**

**REQUIRED IMMUNIZATIONS:** The following immunizations are **required** for all undergraduate students 30 years of age or younger, but strongly recommend for all students, regardless of age. All documentation must be provided in English or include a translation.

## Measles, Mumps & Rubella (MMR): Required for ALL Students

**2 doses of MMR Vaccine**

**Dose 1** received after 1st Birthday: ___/___/_____

**Dose 2** received at least 28 days after 1st dose: ___/___/_____

**OR**

Measles Dose 1: ___/___/_____ Measles Dose 2: ___/___/_____ Mumps: ___/___/_____ Rubella: ___/___/_____

**OR**

Laboratory proof of immunity (MMR IgG Antibody test)

## HEPATITIS B: Required for Students taking more than 12 credits

**3 doses of Hepatitis B Vaccine**

**Dose 1** ___/___/_____ **Dose 2** ___/___/_____ **Dose 3** ___/___/_____

**OR**

Laboratory proof of immunity (Hepatitis B IgG Antibody test)

## Meningitis A, C, Y, W-135: Required for ALL Students Living on Campus—Recommend for ALL students

**Meningococcal of A, C, Y, W-135 (recommended within the last 5 years)**

**Dose 1** ___/___/_____ **Dose 2** ___/___/_____

U.S. Brand ☐ Menveo or menactra Non-U.S. Brand (specify): ___________

NOTE: Trumenba & Bexero are NOT ACYW-135 Vaccines

**DOCTOR:** Give booster dose if given before the age of 16 to continue protection during the age of highest risk (16-23 years)

## Tuberculosis Screening Required for High Risk Students ONLY (See questionnaire)

**Mantoux Date:** ___/___/_____ Reaction ☐ Negative ☐ Positive _______mm

If positive, Date of chest x-ray ___/___/_____ (attach copy of report)

*Student's Name:* ________________________________________ *Date of Birth:* ____/____/________

**RECOMMENDED VACCINATIONS:** The following vaccinations are recommended but not required.

| **Meningitis B: Recommended but not required** |
| --- |
| **Meningococcal of B**<br>**Dose 1** ___/___/_____ **Dose 2** ___/___/_____ **Dose 3** ___/___/_____<br>U.S. Brand ☐ Trumenba or Bexero Non-U.S. Brand (specify): ____________ |

| **Hepatitis A** |
| --- |
| **2 doses**<br>**Dose 1** ___/___/_____ **Dose 2** ___/___/_____ |

| **Varicella** |
| --- |
| **2 doses of Varicella Vaccine**<br>**Dose 1** ___/___/_____ **Dose 2** ___/___/_____ **OR** History of infection ___/___/_____ **OR** provide titers |

| **Tetanus, Diphtheria, Pertussis (Tdap)** |
| --- |
| **Tdap/TD**<br>**Date of most recent (within the past 10 years)** ___/___/_____ |

| **Human Papillomavirus (HPV)** |
| --- |
| Gardasil Dose 1 ___/___/_____ Dose 2 ___/___/_____ |

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Record of Immunization is not valid unless signed & stamped by a Physician, NP, PA

Provider Name: _______________________________________________ Title: ____________________________

Signature: _____________________________________________________ Date: __________________________

Office Telephone: (     ) _______-___________

*Office Stamp (Required)*