Immunization Record

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

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 ___/___/_____

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 **Dose 1** ___/___/_____ **Dose 2** ___/___/_____ **Dose 3** ___/___/_____ U.S. Brand ☐ Trumenba or Bexero Non-U.S. Brand (specify): ___________

Hepatitis A
2 doses **Dose 1** ___/___/_____ **Dose 2** ___/___/_____

Varicella
2 doses of Varicella Vaccine **Dose 1** ___/___/_____ **Dose 2** ___/___/_____ **OR** History of infection ___/___/_____ **OR** provide titers

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

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

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

Provider Name: ____ Title: ____________________________

Signature: ____ Date: __________________________

Office Telephone: (   ) _______-___________

Office Stamp (Required)