IMMUNIZATION RECORD

Student Last Name: **First Name:** **DOB:**

Student ID: **Cell #:** **E-Mail Address:** **Gender:**

I am a: □ **Incoming Freshmen** □ **Transfer Student**
□ **Exchange Student** □ **International Student**

Will you be a resident on campus? □ **Yes** □ **No**

This section must be completed and signed by a health care provider or you may attach a copy of your immunization record with the following immunizations noted. Proof of a positive titer will be accepted for some immunizations in cases where immunization records are not available (Please attach lab results).

Required Immunizations:

MMR (Measles, Mumps, Rubella): Dose #1 ___/___/_____ Dose #2 ___/___/_____
Given on or after 12 months of age **Given at least 28 days after dose #1 and after 1980**

Tdap (Tetanus,diphtheria, Pertussis) (**must be within the past 10 years**): ___/___/_____

Hepatitis B: Dose #1 ___/___/_____ Dose #2 ___/___/_____ Dose #3 ___/___/_____

Meningococal Vaccine: Menomune or Menactra ___/___/_____ **(must be within the past 5 years)**

Varicella (chicken pox): History of disease: □ **Yes** □ **No if yes, when:** ___/___/_____

If **NO** history of disease, 2 doses of **Varivax** required **OR** proof of positive titer (**Attach copy of lab results**)
Dose #1 ___/___/_____ Dose #2 ___/___/_____ ___/___/_____ ☐ reactive ☐ non-reactive

Tuberculosis Testing (TB skin test) or **Quantiferon Gold Test** (**either performed within the past year**):

TB skin Test (PPD Mantoux): ___/___/_____ ___/___/_____ + / - mm induration _____
Date Given Date Read Results

If TB is positive: CXR (**Attach copy of CXR results**) ___/___/_____ **(within the past year)** ☐ Normal ☐ Abnormal

Quantiferon TB-Gold (**Attach copy of lab results**):
Required for all International Students Date Drawn: ___/___/_____ Results: _____

Recommended Immunizations:

Hepatitis A: Dose #1 ___/___/_____ Dose #2 ___/___/_____

HPV(Gardasil): Dose #1 ___/___/_____ Dose #2 ___/___/_____ Dose #3 ___/___/_____

Medical provider signature: _____ M.D. / N.P. / P.A./ D.C.

Medical provider's printed name: _____

Physician's address: _____

Phone: Date form completed: _____

Please return to: Student Health Services