Commuter Student
Immunization Record
NOT CONFIDENTIAL
Immunization records are not confidential as required by law

Name: ___________________________ Male ☐ Female ☐

Last First Middle

Student ID: ___________________________ Date of Birth: _______m m d d y y y y

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR
If convenient, you may attach an official copy of your immunization records, which must include all previous and recent shots

1. REQUIRED IMMUNIZATIONS (Laboratory Report must be submitted for any blood titers)

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>#1 Date</th>
<th>#2 Date</th>
<th>OR</th>
<th>Titers</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR #1</td>
<td></td>
<td>#2 Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles #1</td>
<td>Date</td>
<td>Immune ☐ Non-immune ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps #1</td>
<td>Date</td>
<td>Immune ☐ Non-immune ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella #1</td>
<td>Date</td>
<td>Immune ☐ Non-immune ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B #1</td>
<td>Date</td>
<td>Immune ☐ Non-immune ☐</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

2. TUBERCULOSIS TEST (Must be within the 6 months prior to the start date of student’s first semester)

Mantoux/PPD Test
Date Given _____________ Date Read _____________ Result: Negative ☐ Positive ☐ Size _______ mm (induration)

OR

QuantiFERON-TB Gold or T-spot Test
Date _____________ Result ____________________________ (MUST ATTACH LAB REPORT)

If TB Test is Positive, please complete the Positive TB Test Checklist (Chest X-ray Required)

3. MENINGOCOCCAL MENINGITIS

MENINGOCOCCAL MENINGITIS INFORMATION IS AVAILABLE AT:
http://www.cdc.gov/meningitis and also at www.fdu.edu/shsmetro

Having read the above information, please check one of the following options:

☐ I received the meningitis vaccine on: _______ - _______ - _______

☐ I DO NOT wish to receive the vaccine.

Student Signature: __________________________________________ Date: ______________________

Signature of Medical Provider: _____________________________ Date: __________________ License Number

Medical Provider: _____________________________ Phone: ( ___ ) __________

Address: ____________________________________________ Official Stamp of Medical Provider

Remember! Proof of Immunity is required prior to registration. You will be put on medical hold unless you meet all entrance requirements