**Immunization Record**

**NOT CONFIDENTIAL**
Immunization records are not confidential as required by law

Name: ___________________________ Male □ Female □
Last ____________ First ____________ Middle ____________
Student ID: ___________________________ Date of Birth: ___________________________

**TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR**
If convenient, you may attach a signed 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</th>
<th>#2</th>
<th>OR</th>
<th>Titers</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>#1</td>
<td>#2</td>
<td>Date</td>
<td>Immune □ Non-immune □</td>
</tr>
<tr>
<td>Mumps</td>
<td>#1</td>
<td>#2</td>
<td>Date</td>
<td>Immune □ Non-immune □</td>
</tr>
<tr>
<td>Rubella</td>
<td>#1</td>
<td>#2</td>
<td>Date</td>
<td>Immune □ Non-immune □</td>
</tr>
</tbody>
</table>

Varicella (Chicken Pox)

OR Vaccine #1 ____________ #2 ____________

Hepatitis B

#1 ____________ #2 ____________ #3 ____________

Meningococcal Containing Vaccine: Date ____________ (Required for all Resident Students)

2. **TUBERCULOSIS TEST** (Mantoux/PPD within past 6 months, regardless of prior BCG inoculation)

Mantoux/PPD Test

#1 Date Given ____________ Date Read ____________ Result: Negative □ Positive □ Size ____________ mm (induration)

Nursing Students require a two-step Mantoux. This second step must be 1-3 weeks after the first.

#2 Date Given ____________ Date Read ____________ Result: Negative □ Positive □ Size ____________ mm (induration)

If Mantoux (PPD) is Positive, Chest X-ray and a discussion of Chemoprophylaxis is required:

Chest X-ray Date ____________ Result ____________

Chemoprophylaxis Discussed on ____________ Treatment □ INH □ Other □ Name of Drug

Date Initiated ____________ Dosage ____________ Duration ____________

International Students: BCG Vaccine: No □ Yes □ If Yes, Date Received: ____________

3. **CHILDHOOD IMMUNIZATIONS**

Tetanus, Diphtheria (TD) [within the last 10 years] ____________ OR Tdap ____________

Last Polio Booster ____________ OR Titers: Date ____________ Immune □ Non-immune □

Signature of Medical Provider: ___________________________ Date: ____________
Medical Provider: ___________________________ Phone: ( ) ____________
Address: ___________________________

License Number OR 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