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

**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>
<th>Date</th>
<th>Immune</th>
<th>Non-immune</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Varicella</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>#1</td>
<td>#2</td>
<td>#3</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

**Note:** Measles has to be live, after 1st Birthday

**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 _______________________________ (Please attach Radiologist’s report)
- **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.