Immunization Record

Not Confidential

Immunization records are not confidential as required by law

Name: ___________________________________________ Male ___ Female ___

Last

First

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/stamped 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>Vaccination</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></td>
<td>Date____</td>
</tr>
<tr>
<td>Mumps</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td>Date____</td>
</tr>
<tr>
<td>Rubella</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td>Date____</td>
</tr>
<tr>
<td>Varicella (Chicken Pox) Disease</td>
<td></td>
<td></td>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>Or Vaccine</td>
<td>#1</td>
<td>#2</td>
<td></td>
<td>Date____</td>
</tr>
<tr>
<td>Hepatitis B Vaccine</td>
<td>#1</td>
<td></td>
<td>#2</td>
<td>Date____</td>
</tr>
<tr>
<td>#2</td>
<td></td>
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</tr>
</tbody>
</table>

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)

If Mantoux (PPD) is Positive, Chest X-ray and a discussion of Chemoprophylaxis is required: Please see/download the Positive TB Test Checklist Form

3. Meningococcal Containing Vaccine*

*STUDENTS CANNOT LIVE ON CAMPUS UNLESS THEY PROVIDE PROOF TO STUDENT HEALTH SERVICES THAT THEY RECEIVED A MENINGOCOCCAL MENINGITIS A/C/Y/W-135 VACCINATION WITHIN THE PAST 5 YEARS OF CAMPUS ARRIVAL. MEN B VACCINE IS NOT REQUIRED BUT IT IS RECOMMENDED FOR ALL STUDENTS. **

**Teens and young adults (16 through 23 years old) may also be vaccinated with Men B vaccine (serogroup B meningococcal vaccine, brand names are Bexsero & Trumenba). Two or three doses are needed depending on the brand.

4. Tdap (within the last 10 years) Date______________ (TD Not Acceptable)

Signature of Medical Provider: ___________________________ Date_________

Name of Medical Provider: ___________________________________________

Address: __________________________________________ Phone: _______________

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.