



# IMMUNIZATION RECORD

NAME \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_

Note that the immunizations listed below are **MANDATORY**. Specify the personal, medical or religious reason for any immunization that is not given. Documentation of immunity via **TITERS** is **ACCEPTABLE**.

### TO BE COMPLETED BY YOUR HEALTH CARE PROVIDER

VACCINE	DATE
<b>DPT Series</b> (Date series completed)	
<b>Td/TDAP/Adacel (Circle)</b> (Booster in last 10 years)	
<b>OPV (polio) Series</b> Date, series and booster completed or titer	
<b>MMR # 1</b> (Mumps, Measles, Rubella) 2 doses or immune titer	
<b>MMR # 2</b> (Mumps, Measles, Rubella) 2 doses or immune titer	
<b>Hepatitis B # 1</b>	
<b>Hepatitis B # 2</b>	
<b>Hepatitis B # 3</b>	
<b>Hep B Surface ANTIBODY</b>	Date _____ <input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive
<b>Varivax vaccine # 1</b> (chickenpox vaccine)	
<b>Varivax vaccine # 2</b> (chickenpox vaccine)	
<b>Varivax vaccine TITER</b> (chickenpox titer)	
<b>Meningococcal (RESIDENTIAL STUDENTS)</b> (A/C/Y/W-135) or signed <b>WAIVER</b>	

### Recommended Immunization for Females HPV (Human Papilloma Virus)

3 doses for women (through age 26)

#1 (date)      #2 (date)      #3 (date)

### Meningitis Vaccine Waiver

\_\_\_ **DECLINE:** I have read and understand the above information about meningitis and the benefits of immunization FOR RESIDENTIAL STUDENTS. I decline the meningitis vaccine at this time. I understand in declining this vaccine, I continue to be at risk for this serious disease. **Incoming students may waive this requirement only if there is a medical contraindication to vaccination or if religious beliefs prohibit immunization.**

Print name \_\_\_\_\_

Signature of student \_\_\_\_\_

Date \_\_\_\_\_

Signature of Parent \_\_\_\_\_

Date \_\_\_\_\_

(If student is 17 years of age or younger)

<b>Tuberculosis Testing (PPD) within the last 6 months*</b> required regardless of prior BCG inoculation) <b>Date:</b> <b>Result:</b> <input type="checkbox"/> Neg <input type="checkbox"/> Pos Induration _____ mm <b>Dates of INH therapy:</b>	<b>PA/PT students only: MUST have 2-step PPD (2 wks apart) within the last 6 months*</b> required regardless of prior BCG inoculation) <b>Date:</b> <b>Result:</b> _____ Induration mm <b>Date:</b> <b>Result:</b> _____ Induration mm	If required: Chest X-ray <b>Date:</b> _____ <b>Results:</b> <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal _____ Provider signature
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### Healthcare Provider Information: (Physician, Nurse Practitioner, etc.)

\_\_\_\_\_  
Name of Provider (Please Print)

\_\_\_\_\_  
Phone Number/Fax number

\_\_\_\_\_  
Signature of Provider: (I have informed my patient of any immunization updates needed for completion of above required immunizations)

\_\_\_\_\_  
Address

**PLEASE MAKE A COPY OF THIS ENTIRE FORM (FOR YOUR RECORDS) BEFORE SUBMITTING AND RETURN ORIGINAL FORM TO STUDENT HEALTH CENTER ONLY.**