



IMMUNIZATION RECORD

NAME _____ Date of Birth: _____

Note that the immunizations listed below are **MANDATORY**. Specify the personal, medical or religious reason for any immunization that is not given.

HEALTH CARE PROVIDER to fill out this section of required vaccines

VACCINE	DATE
DPT Series (Date series completed)	
TDAP/Adacel (Circle) (Booster in last 10 years)	
OPV (polio) Series Date, series and booster completed or titer	<u> </u> <u> </u> <u> </u> <u> </u> Fill in all 4 dates please
MMR # 1 (if born after 1956) 2 doses or immune titer	
MMR # 2 2 doses or immune titer	
Hepatitis B # 1	
Hepatitis B # 2	
Hepatitis B # 3	
Hepatitis Titer if vaccination dates are unavailable	
Varicella Disease OR	
Varivax vaccine # 1 AND (chickenpox vaccine if born after 1979 or not born in the USA)	
Varivax vaccine # 2 per CDC guidelines: 2 vaccines required	
Meningococcal (RESIDENTIAL STUDENTS) (A/C/Y/W-135) or signed WAIVER	

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)

<p>Tuberculosis Testing (PPD) within the last 6 months* required regardless of prior BCG inoculation)</p> <p>Date: _____</p> <p>Result: <input type="checkbox"/> Neg <input type="checkbox"/> Pos</p> <p>Induration _____ mm</p> <p>Dates of INH therapy: _____</p>	<p>If required: Chest X-Ray</p> <p>Date: _____</p> <p>Results:</p> <p><input type="checkbox"/> Normal</p> <p><input type="checkbox"/> Abnormal</p> <hr/> <p>Provider Signature</p>
---	--

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.