Student Health Center
Point Park University

**IMPORTANT : RECORDS ARE DUE BEFORE START OF CLASS**

Fall Deadline : August 1  Spring Deadline :  January 1

# NON-RESIDENT IMMUNIZATION FORM

**This form is to be completed by a medical provider. A print-out of your immunization record from a patient portal of physicians office can be submitted in place of this form.** Incoming students must complete the immunization requirements prior to arriving on campus. If you need assistance with getting immunizations, please contact your local health department or primary care physician. The Student Health Center does not provide immunizations.

*Immunization exemption forms can be found on the student health website*

****It is recommended to submit your actual immunization records in addition to or instead of this worksheet. PLEASE NOTE: If you submit this form alone as your proof of immunization history, it must be signed or stamped by your medical provider. If this form is submitted without a medical provider's signature or stamp, it will not be accepted.****

| *Last Name* | *First Name* | *Date of Birth* |
|---|---|---|
| *Student ID Number* | *Student Email Address* | |

| REQUIRED | | | | | |
|---|---|---|---|---|---|
| *VARICELLA (CHICKEN POX)*<br>2 DOSES REQUIRE OR DATE OF ILLNESS | ILLNESS DATE | DOSE #1 | DOSE #2 | **OR** LABORATORY EVIDENCE OF IMMUNITY<br>**UPLOAD LAB REPORT** |
| *MMR*<br>2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISETERED AFTER 1ST BIRTHDAY | | DOSE #1 | DOSE #2 | |
| -OR- | | | | |
| *MEASLES (RUBEOLA)*<br>2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY | | DOSE #1 | DOSE #2 | **OR** LABORATORY EVIDENCE OF IMMUNITY<br>**UPLOAD LAB REPORT** |
| *MUMPS*<br>2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY | | DOSE #1 | DOSE#2 | **OR** LABORATORY EVIDENCE OF IMMUNITY<br>**UPLOAD LAB REPORT** |
| RUBELLA (GERMAN MEASLES)<br>1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY | | DOSE #1 | | **OR** LABORATORY EVIDENCE OF IMMUNITY<br>**UPLOAD LAB REPORT** |

| INTERNATIONAL **STUDENTS** | | | |
|---|---|---|---|
| *POLIO* *REQUIRED*<br>4-DOSE SERIES AT AGES 2, 4, 6–18 MONTHS, 4–6 YEARS | Dates RECEIVED | | |
| *TUBERCULIN SKIN TEST *REQUIRED**<br>WITHIN ONE YEAR (MANTOUX) OR CHEST X-RAY | PLANTED | READ | |

| PROVIDER INFO | | | |
|---|---|---|---|
| **SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE** | | | |
| PROVIDER NAME (PLEASE PRINT) | | | TITLE |
| ADDRESS | | PHONE | PRACTICE NAME |
| SIGNATURE | | DATE | CLINICAL OR ORGANIZATION STAMP |

REV 8/23