

### STUDENT IMMUNIZATION RECORD

**This form is to be completed by a medical provider.** 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. MyHealth@School does not provide immunizations.

**\*\*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	

<b>REQUIRED</b>	<b>HEPATITIS B</b> 3 DOSES REQUIRED	DOSE #1	DOSE #2	DOSE #3	OR LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT
	<b>TDAP (Tetanus, Diphtheria, Pertussis )</b> ONE-TIME DOSE AFTER AGE 10 (ADACEL OR BOOSTRIX)	TDAP DATE	CIRCLE ONE : TDAP OR TD (IF TDAP IS GREATER THAN 10 YEARS)		LAST BOOSTER DATE
	<b>VARICELLA (CHICKEN POX)</b> 2 DOSES REQUIRE OR DATE OF ILLNESS	ILLNESS DATE	DOSE #1	DOSE #2	OR LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT
	<b>MENINGOCOCCAL ACYW-135</b> DOSE SINCE AGE OF 16   21 OR YOUNGER LIVING IN CAMPUS HOUSING	LAST DOSE	LIST VACCINE NAME OR SEROGROUPS COVERED: _____		
	<b>MMR</b> 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2		
	-OR-				
	<b>MEASLES (RUBEOLA)</b> 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	OR LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT	
	<b>MUMPS</b> 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1	DOSE #2	OR LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT	
	<b>RUBELLA (GERMAN MEASLES)</b> 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY	DOSE #1			OR LABORATORY EVIDENCE OF IMMUNITY UPLOAD LAB REPORT

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

<b>RECOMMENDED</b>	<b>HEPATITIS A</b>	DOSE #1	DOSE #2	
	<b>HPV (HUMAN PAPILOMAVIRUS)</b> <input type="checkbox"/> HPV4 <input type="checkbox"/> HPV9	DOSE #1	DOSE #2	DOSE #3
	<b>INFLUENZA</b> YEARLY VACCINE	DATE OF LAST VACCINE		

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