

### Immunization Record Form

*Use this form if you do not have other proof of immunizations. (Please print in black ink. To be completed and signed by physician or clinic. A complete official immunization record from a physician or clinic may be attached to this form. Student to confirm identifying information above is complete before submission.)*

Last Name	First Name	MI	____/____/____ Date of Birth	_920____ Student ID#
Address		City	State	Zip

SECTION A:	REQUIRED IMMUNIZATIONS			
	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DTP or Td or Tdap	(#1)	(#2)	(#3)	(#4)
Tdap booster (If due update after 7/2008)				
Td Booster				
Polio				
MMR (after 1 <sup>st</sup> birthday)	(#1)	(#2)		
Measles/Rubella (MR) (after 1 <sup>st</sup> birthday)				
Measles (after 1 <sup>st</sup> birthday)			**Disease Date	Titer Date & Result
Mumps			<input type="checkbox"/> Not Acceptable ***Disease Date	Titer Date & Result
Rubella			<input type="checkbox"/> Not Acceptable ***Disease Date	Titer Date & Result
TB (PPD) Skin Test (Within 12 months) (ONLY required for international students)	Date Read	mm indurations		
Attach chest x-ray results if positive PPD	Date	Results		

SUBMIT  
LAB  
RESULTS

SECTION B:	RECOMMENDED IMMUNIZATIONS			
Received the meningococcal vaccine?	<input type="checkbox"/> YES <input type="checkbox"/> NO   Which Vaccine? <input type="checkbox"/> Menactra <input type="checkbox"/> Menomune   Date:			
Hepatitis B series ONLY				****Titer Date & Result
Hepatitis A/B combination series				
<b>Varicella (chicken pox) series of two doses or immunity by positive blood titer</b>			Disease Date	****Titer Date & Result

SECTION C:	OPTIONAL IMMUNIZATIONS			
	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
Haemophilus influenzae type b				
Pneumococcal				
Hepatitis A series				
HPV (Gardasil)				
<b>Other:</b>				

**SIGNATURE OR CLINIC STAMP REQUIRED:**

\_\_\_\_\_  
Signature of Physician/PA/NP

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Physician/PA/NP

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Office/Clinic Address

\_\_\_\_\_  
City

\_\_\_\_\_  
State

\_\_\_\_\_  
Zip Code

\*\*Must repeat Rubeola (measles) vaccine if received more than 4 days prior to 12 months of age. History or physician-diagnosed measles disease is acceptable, but must have signed statement from physician.  
 \*\*\*Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.  
 \*\*\*\*Laboratory Report must be submitted.

