IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

NAME _____ (LAST) _____ (FIRST) _____ (M. I.)

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER (Dates must include month and year.)

A. TETANUS-DIPTHERIA *(Required)

1. ☐ Completed primary series of tetanus-diptheria immunizations ..... MONTH DATE YEAR
2. ☐ Received tetanus-diptheria booster (required every 10 years) ..... MONTH DATE YEAR
3. ☐ Tdap (preferred) to replace single dose of Td for booster immunization with at least five years since last dose of Td ..... MONTH DATE YEAR

B. M.M.R. (Measles, Mumps, Rubella) *(Required)

1. ☐ Dose 1 – Immunization date required at exactly 12 months or after and before 5 years ..... MONTH DATE YEAR
2. ☐ Dose 2 – Immunized at 5 years or later ..... MONTH DATE YEAR

***C. MEASLES (Rubeola) – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with live measles vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

***D. RUBELLA – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

***E. MUMPS – if given instead of MMR. Check appropriate box.**

1. ☐ Has report of immune titer. **Specify date and send copy of positive results.** ..... MONTH DATE YEAR
2. ☐ Immunized with vaccine at 12 months after birth or later. ..... MONTH DATE YEAR

F. TUBERCULOSIS – Interpretation based on mm of induration. *Check appropriate box.*

***(Required of International Students Only)**

1. ☐ PPD (Mantoux) test within the past year (Tine or monovac not acceptable)
   Give date placed ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
   Give date read and results (based on millimeters) ..... Date MONTH DATE YEAR — _____ mm
2. ☐ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray ..... Date MONTH DATE YEAR — Result: ☐ Positive ☐ Negative
3. ☐ Had BCG vaccine – Chest x-ray required if PPD not done ..... Date MONTH DATE YEAR

G. POLIO *(Required)

1. ☐ Completed primary series of polio immunization ..... ☐ Yes ☐ No MONTH DATE YEAR
   Type of vaccine: ☐ Oral ☐ Inactivated ☐ E-IPV
   Last booster ..... MONTH DATE YEAR

H. MENINGOCOCCAL MENINGITIS *(Required)

1. ☐ MENOMUNE - **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR
2. ☐ Menactra - (Conjugate) **Immunization and updates as per CDC guidelines.** ..... MONTH DATE YEAR

I. ☐ HEPATITIS B VACCINE SERIES *(RECOMMENDED OR WAIVER)* ..... MONTH DATE YEAR

***(Required for Health Care Profession Students)**

MONTH DATE YEAR

MONTH DATE YEAR

HEALTH CARE PROVIDER

Name _____ Address _____

Signature _____ Phone (____) _____

HC (Revised 03/15)