IMMUNIZATION RECORD

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

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

*A. TETANUS-DIPHTHERIA (Required)

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

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

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

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

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

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

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

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

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

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
   Give date read and results (based on millimeters) ..........................................Date
   Result: □ Positive □ Negative mm

2. □ Positive PPD – Chest x-ray required.
   Give date and result of chest x-ray .............................................................................Date
   Result: □ Positive □ Negative

3. □ Had BCG vaccine – Chest x-ray required if PPD not done ........Date

*G. POLIO (Required)

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

*H. MENINGOCOCCAL MENINGITIS (Required)

1. □ MENOMUNE - Immunization and updates as per CDC guidelines...............................
2. □ Menactra - (Conjugate) Immunization and updates as per CDC guidelines..............

I. □ HEPATITIS B VACCINE SERIES (RECOMMENDED OR WAIVER).............................

*(Required for Health Care Profession Students)

HEALTH CARE PROVIDER

Name ........................................... Address ...........................................

Signature ........................................... Phone (____) ____________________________

HC (Revised 03/15)