Student Immunization Form

Last Name: ____________________________ **First Name**: _________________________ **Middle Initial:** ________

Date of birth: ____________________________ **Entering semester/year:** ______________________________

Required Immunizations/Vaccinations

MMR (Measles, Mumps, Rubella) – 2 doses of MMR vaccine **or** two (2) doses of Measles, two (2) doses of Mumps and (1) dose of Rubella; **or** serologic proof of immunity for Measles, Mumps and/or Rubella (**results must be attached.)**

Option 1	**Vaccine**	**Date**	
MMR – 2 doses of MMR vaccine	MMR Dose #1	____/____/____	
	MMR Dose #2	____/____/____	

Option 2	**Vaccine or Test**	**Date**	
Measles – 2 doses of vaccine or positive serology	Measles Vaccine Dose #1	____/____/____	
	Measles Vaccine Dose #2	____/____/____	
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	(Copy attached)
Mumps - 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	____/____/____	
	Mumps Vaccine Dose #2	____/____/____	
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	(Copy attached)
Rubella - 1 dose of vaccine or positive serology	Rubella Vaccine	____/____/____	
	Serologic Immunity (IgG, antibodies, titer)	____/____/____	(Copy attached)

Tetanus-diphtheria-pertussis - One (1) dose of adult Tdap or last Td (tetanus) not more than 10 years old. If last Tdap is more than 10 years old, provide date of last Td or Tdap booster.

	Date
TDap Vaccine (Adacel,Boostrix, etc.)	___/___/____
Td Vaccine or Tdap Vaccine Booster (if more than 10 years since last Tdap)	___/___/____

Meningococcal Vaccine - 1 dose required.

Meningococcal ACWY **Date** ___/___/___

Name: ____ **Date of Birth:** _________________________
(Last, First, Middle Initial) (mm/dd/yyyy)

Varicella (Chicken Pox) - 2 doses of vaccine **or** positive serology **(results must be attached).**

	Date	
Varicella Vaccine #1	___/___/____	
Varicella Vaccine #2	___/___/____	
Serologic Immunity (IgG, antibodies, titer)	___/___/____	(Copy attached)

Hepatitis B Vaccination - Document the primary Hep B series received as a child. **All individuals must have a QUANTITATIVE Hepatitis B Surface Antibody titer drawn to determine current immunity status as an adult**. If negative titer results are returned, then complete a secondary Hepatitis B Series followed by a repeat titer. *If repeating secondary series, dose 4 must be received and documented before classes begin. Continuing receipt of secondary series must be documented as required to prevent future registration holds; however, receipt of all repeated doses is not required before classes begin!* For those that do not have documentation of initial 3 dose series as a child, perform titer to determine further course of action as recommended by healthcare practitioner. If Hepatitis B Surface Antibody is negative after a secondary series, additional testing including Hepatitis B Surface Antigen should be performed.

		Date	
Primary Hepatitis B Series	Hepatitis B Vaccine Dose #1	___/___/____	
	Hepatitis B Vaccine Dose #2	___/___/____	
	Hepatitis B Vaccine Dose #3	___/___/____	
	Quantitative Hep B Surface Antibody	___/___/____	Result ____mIU/ml (Copy attached)
Secondary Hepatitis B Series (if no response to primary series)	Hepatitis B Vaccine Dose #4	___/___/____	
	Hepatitis B Vaccine Dose #5	___/___/____	
	Hepatitis B Vaccine Dose #6	___/___/____	
	Quantitative Hep B Surface Antibody	___/___/____	Result ____mIU/ml (Copy attached)
Hepatitis B Vaccine Non-responder (If Hepatitis B Surface Antibody Negative after Primary and Secondary Series)	Hepatitis B Surface Antigen (if 2nd titer negative)	___/___/____	(Copy attached)
	Hepatitis B Core Antibody (if 2nd titer negative)	___/___/____	(Copy attached)

COVID-19 Vaccination (Please provide copy of your vaccine card front and back). If requesting waiver, please complete the COVID waiver form.

Influenza Vaccine – 1 dose required for current flu season, if entering school May or January.
August entering students will receive vaccine on campus so do not complete at this time.

	Date	
Flu Vaccine	____/___/___	(Copy Attached)

Name: ____ **Date of Birth:** ___________________________
(Last, First, Middle Initial) (mm/dd/yyyy)

Tuberculosis Screening – Results of last **(2) TSTs (PPDs)** should be documented. (One TST (PPD) must be documented for the current *calendar year*). A prior test may also be documented if taken and read in prior calendar year. **, or** (1) IGRA blood test are required regardless of prior BCG status.

Tuberculin Screening History

Section A			**Date Placed**	**Date Read**	**Reading**	**Interpretation**
Negative Skin or Blood Test History	**TST #1**		____/___/___	___/___/___	____mm	☐ Pos ☐ Neg ☐ Equiv
	TST #2		____/___/___	___/___/___	____mm	☐ Pos ☐ Neg ☐ Equiv
				Date	**Result**	
Last two skin test or IGRA required	**IGRA Blood Test** (Interferon gamma releasing assay)			___/___/___	☐ Negative ☐ Indeterminate	☐ Copy Attached
Section B			**Date Placed**	**Date Read**	**Reading**	**Interpretation**
History of Latent Tuberculosis, Positive Skin Test or Positive Blood Test	**Positive TST**		____/___/___	___/___/___	____mm	
				Date	**Result**	
	Positive IGRA Blood Test			___/___/___	_____ IU	☐ Copy Attached
	Chest X-ray			___/___/___		☐ Copy Attached
	Prophylactic Medications for latent TB taken?					☐ Yes ☐ No
	Total Duration of prophylaxis?					_____ **Months**
	Date of Last Annual TB Symptom Questionnaire (if applicable)				___/___/____	☐ Copy Attached

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Healthcare Provider (mid–level practitioner or physician must complete this section)
I verify that this information is true.

Authorized signature: ___________________________________ Date: ____/____/_____

Printed Name: ____

Title: ____

Address: ____

City: _________________________________ State: ___________ Zip Code: _______________________

Phone: (____) ________-____________ Ext: _______________
Fax: (____) _______-_______________ Email contact: ____

Updated 7/2022