

Immunization Record

To be completed and signed by health care provider.* ALL DATES MUST INCLUDE MONTH, DAY AND YEAR.

SOCIAL SECURITY NUMBER _____ - _____ - _____

LAST NAME (PLEASE PRINT) _____ FIRST _____

() Male () Female

STUDENT I.D. NUMBER _____ DATE OF BIRTH (MONTH/DAY/YEAR) _____ SEX ASSIGNED AT BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

Required Immunizations	1 MO DAY YR	2 MO DAY YR	3 MO DAY YR	4 MO DAY YR	5 MO DAY YR
Diphtheria, Pertussis and Tetanus (DPT)					
Diphtheria and Tetanus (Td or TD)					
Combined Measles, Mumps/Rubella (MMR)					
Combined Measles and Rubella (MR)					
Rubeola (Red Measles) Live Virus Vaccine					
Rubella (3-day or German Measles)					
Mumps					

1. Clinic diagnosis of rubeola and mumps acceptable if verified by physician with specific date.
 Rubeola: _____ / _____
 Mumps: _____ / _____
 2. **Lab confirmation** of rubella, rubeola or mumps is acceptable. ATTACH COPY OF LAB RESULTS.

Meningitis #1 _____ #2 _____

1. First dose given between ages 11-16.
 2. Booster dose given on or after age 16.

TUBERCULOSIS (for non-U.S. residents only)

1. Tuberculin Skin Test: Date Given _____ Date Read _____
 (MONTH/DAY/YEAR) (MONTH/DAY/YEAR)

Result: _____ [Record actual mm of induration, transverse diameter, if no induration, write "0"]

Interpretation (based on mm of induration as well as risk factors): Positive _____ Negative _____

2. Chest x-ray (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

_____ INH _____
 (MONTH/DAY/YEAR) (MONTH/DAY/YEAR)

Optional Immunizations:

Hepatitis B (please record dates given) #1 _____ #2 _____ #3 _____

COVID 19 Vaccine (Vaccine Manufacturer) _____
 (please record dates given) #1 _____ #2 _____ #3 _____

PHYSICIAN OR OTHER HEALTH CARE PROVIDER SIGNATURE AND TITLE _____

NAME (PRINT) _____

ADDRESS _____

TELEPHONE _____

*Physician licensed to practice medicine in all of its branches (M.D. or D.O.) or local health authority or Registered Nurse employed by a school, college, or university or a Department Recognized Vaccine Provider.

Exemption: Religious: _____ Medical: _____ Immune: _____

FOR OFFICE USE ONLY

Reviewed by _____ Date _____ [] Complete [] Incomplete