– IMMUNIZATION RECORD –

Immunity is required prior to registration. Proof of immunization is required.

Name _____
Last *First* *M.I.*

Address _____
Street *City* *State* *ZIP*

Date of entry ____/____ (*Mo* *Yr*) Date of birth ____/____/____ (*Mo* *Dy* *Yr*) SS#_____-____-_____ Phone (____)_____

Transfer student? Yes ___ No ___ Status: Freshman ___ Sophomore ___ Junior ___ Senior ___

——TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER ——

TETANUS/DIPTHERIA

- Received Tetanus/Diptheria booster within the last 10 years . . . . . ____/____ (*Mo* *Yr*)

M.M.R. (Measles, Mumps, Rubella) - Two doses required or individual vaccine as noted below 1. ____/____ (*Mo* *Yr*) 2. ____/____ (*Mo* *Yr*)

MEASLES (Rubeola)

- Immunized with live measles vaccine at 12 months after birth or later and after 1980 . . . 1. ____/____ (*Mo* *Yr*) 2. ____/____ (*Mo* *Yr*)

RUBELLA (German Measles)

- Immunized with live vaccine at 12 months after birth or later and after 1980 . . . . . 1. ____/____ (*Mo* *Yr*) 2. ____/____ (*Mo* *Yr*)

MUMPS

- Immunized with live vaccine at 12 months after birth or later and after 1980 . . . . . 1. ____/____ (*Mo* *Yr*) 2. ____/____ (*Mo* *Yr*)

TUBERCULOSIS (PPD-T Mantoux)

- Within the past 12 months (*tine* or *momovac* not acceptable)
  Result: Neg _____ Pos_____ mm induration . . . . . ____/____ (*Mo* *Yr*)
- If positive, chest X-ray required. X-ray result: Normal ____ Abnormal ___

POLIO

- Completed primary series of polio immunizations: Yes ___ No ___ Date of last booster . . . . . ____/____ (*Mo* *Yr*)
- Type of vaccine: Live (OPV) _____ Inactivated (IPV) _____

HEPATITIS B (Recommended)

- Dose #1. ____/____/____ (*Mo* *Day* *Yr*) Dose #2. ____/____/____ (*Mo* *Day* *Yr*) Dose #3. ____/____/____ (*Mo* *Day* *Yr*)

VARICELLA (Chicken Pox)

- Had disease? Yes ___ No ___ Vaccinated? Yes ___ No ___ If yes, ... ____/____ (*Mo* *Yr*)

MENOMUNE (Meningitis vaccine; Recommended for college students) . . . . . ___/___ (*Mo* *Yr*)

- *Had disease? Yes ___ No ___*

_____
Signature of health care provider

(*forms 12/99)*