IMMUNIZATION RECORD

Name_____ _____
Last Name First Name

Date of Entry ___/___ Date of Birth ___/___/___ Social Security Number ___/___/___/-/___/___/-/___/___/___/___

Status Residential Student Yes/No PT ____ FT ____ Athlete ____ Education Major ____

REQUIRED

A. Tetanus-Diphtheria

1. Tetanus-Diphtheria booster must be within the last ten years.....___/___
Mo Yr

B. M.M.R.(Measles, Mumps, Rubella) (*two doses required* or individual vaccine as noted below)

1. Dose 1 given at 12 months after birth or later and Dose 2 after 1980.....1.___/___ 2.___/___
Mo Yr Mo Yr
2. Born before 1957 and therefore considered immune Yes____ No____

C. Measles (Rubeola) (check all that apply)

1. Immunized with live measles vaccine at 12 months after birth or later and after 1980 1.___/___ 2 .___/___
Mo Yr Mo Yr
2. Has report of positive immune titer. Specify date.....___/___
Mo Yr
3. Had disease confirmed by doctor's records.....___/___
Mo Yr

D. Rubella (German Measles) (clinical history is not acceptable) (check all that apply)

1. Immunized with live vaccine at 12 months after birth or later and after 1980.....1.___/___ 2.___/___
Mo Yr Mo Yr
2. Has report of positive immune titer. Specify date.....___/___
Mo Yr

E. Mumps (check all that apply)

1. Immunized with live vaccine at 12 months after birth or later and after 1980.....1.___/___ 2.___/___
Mo Yr Mo Yr
2. Has report of positive immune titer. Specify date.....___/___
Mo Yr
3. Had disease confirmed by doctor's records.....___/___
Mo Yr

F. Tuberculosis (PPD required regardless of prior BCG inoculation)

1. PPD (Mantoux) within the past 12 months (tine or monovac not acceptable)
Result: Neg____ Pos____ mm induration (horizontal diameter)____.....___/___
Mo Yr
2. If greater than 5 mm induration, chest X-ray required. X-ray result: Normal____ Abnormal____
3. Received BCG: Yes____ No____ If yes.....___/___
Mo Yr

G. Meningococcal Meningitis.....___/___
Mo Yr

RECOMMENDED

H. Polio

1. Completed primary series of polio immunization: Yes____ No____ Date of last booster.....___/___
Mo Yr
2. Type of vaccine: Live (OPV)____ Inactivated (IPV)____ Enhanced Potency (EP-IPV)____

I. Hepatitis B .....1. ___/___ 2. ___/___ 3. ___/___
Mo Yr Mo Yr Mo Yr

Hepatitis B surface antigen antibody ___/___ Reactive____ Non-reactive____
Mo Yr

J. Varicella (Chicken Pox) Rx of Disease Yes____ No____.....Vaccinated 1. ___/___ 2. ___/___
Mo Yr Mo Yr

Health Care Provider

Name _____ Address _____

Signature _____ Phone _____ Date _____