# STUDENT IMMUNIZATION RECORD

***Any matriculated or non matriculated student taking more thatn 5 credits hours is required by PHL 2165 and 2167.***

**PART I**

Name ______________________________ ______________________________
First Name Middle Name

______________________________
Last Name

Address ______________________________
Street City State Zip

Date of Entry ____/________ (M Y) Date of Birth ____/____/________ (M D Y) School ID# ______________________

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____ Professional

## PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

***All information must be in English.***

### A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ........................................ #1 ____/____/________ (M D Y)
2. Dose 2 given at least 28 days after first dose . ........................................ #2 ____/____/________ (M D Y)

### B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

   a. Dose #1 ____/____/________ (M D Y) b. Dose #2 ____/____/________ (M D Y)

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/________ (M D Y)

### C. SEROGROUP B MENINGOCOCCAL

1. MenB-RC (Bexsero) __ routine ____outbreak –related

   a. Dose #1 ____/____/________ (M D Y) b. Dose #2 ____/____/________ (M D Y)

OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related

   a. Dose #1 ____/____/________ (M D Y) b. Dose #2 ____/____/________ (M D Y) c. Dose #3 ____/____/________ (M D Y)

### D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/________ (M D Y)
2. Date of most recent booster dose: ____/____/________ (M D Y) Type of booster: Td _____ Tdap _____

### E. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV3) _____ Live attenuated influenza vaccine (LAIV) _____

Date of last dose: ____/____/________ (M D Y)

## F. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/________ b. Dose #2 ____/____/
   M D Y M D Y

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/_______
   M D Y M D Y M D Y

## G. HEPATITIS B

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_______ b. Dose #2 ____/____/_______ c. Dose #3 ____/____/_______
   M D Y M D Y M D Y
   Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____ Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_______ b. Dose #2 ____/____/_______ c. Dose #3 ____/____/_______
   M D Y M D Y M D Y

3. Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country and/or men who have sex with men; required for health science students).

   Date ____/____/________ Result: Reactive ________ Non-reactive ________

## H. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ c. Dose #3 ____/____/________
M D Y M D Y M D Y

## I. VARICELLA

1. Immunization

   a. Dose #1 . .......................................................................................................................... #1 ____/____/_______
   M D Y

   b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. ....................................... #2 ____/____/_______
   and at least 4 weeks after first dose if age 13 years or older. M D Y

2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

## J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _______ Date ____/____/_______ PPSV 23 _______ Date ____/____/_______
M D Y M D Y

## K. POLIO

1. OPV alone (oral Sabin three doses): #1 ____/____/_______ #2 ____/____/_______ #3 ____/____/_______
   M D Y M D Y M D Y

2. IPV/OPV sequential: IPV #1 ____/____/_______ IPV #2 ____/____/_______ OPV #3 ____/____/_______ OPV #4 ____/____/_______
   M D Y M D Y M D Y M D Y

3. IPV alone (injected Salk four doses): #1 ____/____/_______ #2 ____/____/_______ #3 ____/____/_______ #4 ____/____/_______
   M D Y M D Y M D Y M D Y

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## HEALTH CARE PROVIDER

Name _______________________________________________ Signature _____________________________________________________

Address ____________________________________________________________ Phone (__________)________________________________