REQUIRED IMMUNIZATIONS

A. MMR (Measles, Mumps, Rubella) Vaccine. Two doses required for all students born after 12/31/56.
   Dates: 1._____/_____/____ 2._____/_____/____
   OR individual vaccine/proof of immunity as noted below.
   a. Measles (Rubeola). Check all that apply:
      Vaccine Dates: 1._____/_____/____ 2._____/_____/____
      Has report of positive immune titer. Date:____/_____/____ attach copy of titer report
   b. Rubella (German Measles) Clinical history is not acceptable. Check all that apply.
      Vaccine Dates: 1._____/_____/____ 2._____/_____/____
      Has report of positive immune titer. Date:____/_____/____ attach copy of titer report
   c. Mumps Check all that apply.
      Vaccine Dates: 1._____/_____/____ 2._____/_____/____
      Has report of positive immune titer. Date:____/_____/____ attach copy of titer report

B. Diphtheria-Tetanus-Pertussis
   Dates of primary series: 1._____/_____/____ 2._____/_____/____ 3._____/_____/____ 4._____/_____/____ 5._____/_____/____
   Date of last booster within the last 10 years. Td, TT, or Tdap (circle one): Date:____/_____/____

C. Polio
   Dates of primary series: 1._____/_____/____ 2._____/_____/____ 3._____/_____/____ 4._____/_____/____
   Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____
   Booster (optional): Date:____/_____/____; Type of vaccine: Oral (OPV)_____ Inactivated (IPV)_____

D. Varicella (Chicken Pox) One of the following is required:
   Documentation of positive varicella titer. Date:____/_____/____ attach copy of titer report
   (if negative, varicella immunization required)
   OR
   Vaccine: One dose of vaccine is required if given prior to age 13. Two doses are required if given after age 13.
   Dates: 1._____/_____/____ 2._____/_____/____
Appendix D

E. **Hepatitis B Vaccine** - Three doses and positive titer required.
   Name and Address of where immunization was obtained:
   1st dose Date:_____/_____/_____ ______________________________
   2nd dose Date:_____/_____/_____ (1 month after 1st dose) _______________ 
   3rd dose Date:_____/_____/_____ (6 months after 1st dose) ________________________

   **AND**

   **Hepatitis B Titer** (HbsAB or Anti-HBs – antibody to hepatitis B surface antigen)
   Immunity demonstrated by hepatitis B titer - *attach copy of titer report.*
   Date:_____/_____/_____ Positive/Reactive______ Negative/Nonreactive_____ (if neg. see immunization policy)

F. **Tuberculosis Skin Test** - PPD (Mantoux) – One-step TB skin test required initially and annual TB skin test thereafter.

   One-Step TB Skin Test
   Step 1 (Date placed) _____/_____/_____ (Date read) _____/_____/_____ Results:_______mm
   History of Positive TB Skin Test: Date _____/_____/_____ 
   Documentation of chest x-ray & treatment required.
   History of BCG vaccination: Date _____/_____/_____ 
   TB skin test required regardless of prior BCG vaccination.

**RECOMMENDED IMMUNIZATIONS:**
Meningococcal Vaccine (Meningitis vaccine). Recommended for students living in college dormitories whom have not been immunized previously or for college students less than 25 years of age who wishes to reduce their risk.
Date:_____/_____/_____
Influenza vaccine. Recommended annually for healthcare providers.
Date:_____/_____/_____

*A copy of titer reports (i.e. hepatitis B, varicella, mumps, rubella, rubeola )
must be provided with this form as indicated above.

**SIGNATURE**

________________________________________
Date ____/____/_____
*Must be signed by Physician or Nurse*

**PRINT NAME**

________________________________________
Hospital/Clinic Address of physician or nurse verifying this information:

________________________________________________________________________

__________________________________________________________________

Telephone number of hospital/clinic: (_____)__________________________________

Revised 1/28/2015