

Your Healthcare Provider must complete the following:

(Attaching a print-out of your records is also acceptable)

Immunizations

Patient Name: _____ **Birthdate:** ____/____/____
Last First MI

Living on campus: ☐ Yes * ☐ No

Immunizations **REQUIRED** of all students entering

❖ **Tuberculosis Screening – Please complete TB Screening form page 3 & 4.**

❖ **MMR – Measles, Mumps, Rubella**

- Dates of vaccinations: 1) _____ 2) _____ **OR**
- Documentation of Laboratory immunity with dates:
 - Measles IgG antibody date: _____ ☐ immune ☐ non-immune
 - Mumps IgG antibody date: _____ ☐ immune ☐ non-immune
 - Rubella IgG antibody date: _____ ☐ immune ☐ non-immune
 - _____

❖ **Tdap / Td - Tetanus/Diphtheria/Pertussis – recent w/in 9 years**

- Date: _____

❖ **Meningococcal Vaccine – * Required for residents**

- Date of vaccination: _____, if over 5 years a booster is required.
Date of booster: _____

❖ **Varicella (chicken pox) * Required for residents; Hx of disease must be **verified** by blood test indicating immunity.**

- Dates of 2 doses: 1) _____ 2) _____ **OR**
- Varicella IgG antibody date: _____ ☐ immune ☐ non-immune

Health Care Provider: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Signature: _____ **Date:** _____