Your Healthcare Provider must complete the following or

<u>attaching a print-out of your records</u> is also acceptable.

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

Living on campus: □ **Yes *** □ **No**

Immunizations **<u>REQUIRED</u>** 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
- **COVID-19 – Must attach proof with manufacturer noted**
  - Dates(s) of vaccination(s): 1) _____ 2) _____

- **Tdap / Td - Tetanus/Diphtheria/Pertussis – recent w/in 9 years**
  - Date: _____

- **Meningococcal Vaccines – * Required if living on-campus:**
  - Date of vaccination: _____, if over 5 years a booster is required.
    Date of booster: _____

- **Varicella (**chicken pox) * **Required if living on campus**;
  - Dates of 2 doses: 1) _____ 2) _____ OR
  - Varicella IgG antibody date: _____ □ immune □ non-immune OR
  - Attestation of history of illness: _____

Health Care Provider: _____Phone: _____

Address: _____

City: _____ State: _____ Zip:_____

Signature: _____ Date: _____