


IMMUNIZATION FORM FOR MEDICAL STUDENTS

LAST NAME:		FIRST NAME:		MI:
STUDENT ID (8-DIGITS):		DATE OF BIRTH:	SEX: <input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
PHONE NUMBER:		E-MAIL:		
FIRST QUARTER ATTENDING: <input type="checkbox"/> AUTUMN <input type="checkbox"/> WINTER <input type="checkbox"/> SPRING <input type="checkbox"/> SUMMER _____				YEAR:

BELOW SECTIONS TO BE COMPLETED BY A HEALTH PROVIDER. DATES SHOULD BE FORMATTED AS MM/DD/YYYY.

REQUIRED VACCINES	MMR (Combined Measles, Mumps, Rubella) - 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW	DOSE #1 DATE (ON OR AFTER FIRST BIRTHDAY & AFTER 1/1/68):	DOSE #2 DATE (AT LEAST 28 DAYS AFTER FIRST MMR DOSE):	AND MUST PROVIDE DATE OF BLOOD TITER FOR MEASLES, MUMPS, AND RUBELLA; RESULTS; AND COPY OF LAB TEST. PLEASE COMPLETE THE BELOW FIELDS. 
	-OR-			
	Measles (Rubeola) - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH
	Mumps - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH
	Rubella (German Measles) - 2 DOSES REQUIRED. BOTH MUST BE DONE ON OR AFTER FIRST BIRTHDAY, AND AT LEAST 28 DAYS APART. - MUST PROVIDE DATE OF BLOOD TITER, RESULTS, AND COPY OF LAB TEST.	DOSE #1 DATE:	DOSE #2 DATE:	BLOOD TITER DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH
Tetanus/Diphtheria/Pertussis 3 DOSES OF DTP, DPT, DTaP, TD, Td, OR Tdap ARE REQUIRED. - ONE DOSE MUST BE Tdap . - THE FIRST TWO DOSES MUST BE AT LEAST 28 DAYS APART. - LAST DOSE MUST HAVE BEEN RECEIVED WITHIN 10 YEARS PRIOR TO THE TERM OF CURRENT ENROLLMENT. - TETANUS TOXOID IS NOT ACCEPTABLE IN FULFILLING THIS REQUIREMENT.				
Tdap DATE:		DTP, DPT, DTaP, TD, DT, OR Tdap DATE: (PLEASE CIRCLE THE TYPE OF DOSE)		DTP, DPT, DTaP, TD, DT, OR Tdap DATE: (PLEASE CIRCLE THE TYPE OF DOSE)

STUDENT NAME: _____ STUDENT ID (8-DIGITS): _____

DATES SHOULD BE FORMATTED AS MM/DD/YYYY.

REQUIRED VACCINES	Hepatitis B - THREE DOSES GIVEN AT 0, 1-2, AND 4-6 MONTHS. - BLOOD TITER TEST MAY BE COMPLETED DURING FIRST QUARTER	DOSE #1 DATE:	DOSE #2 DATE:	DOSE #3 DATE:	ANTIBODY BLOOD TITER DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH
	Varicella (Chicken Pox) - MUST PROVIDE BLOOD TITER, OR - DATES OF VACCINES IF YOU HAVE NOT HAD CHICKEN POX	DOSE #1 DATE:	DOSE #2 DATE:	-OR-	BLOOD TITER DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH
	Meningococcal Conjugate - REQUIRED FOR ALL NEW STUDENTS UNDER THE AGE OF 22. - ONE DOSE MUST HAVE BEEN GIVEN ON OR AFTER 16 TH BIRTHDAY.				VACCINE DATE:

COMPLETE ONE OF THE BELOW. DATES SHOULD BE FORMATTED AS MM/DD/YYYY.

TUBERCULOSIS SCREENING	Tuberculin Skin Test (Mantoux Only) TO BE COMPLETED WITHIN 3 MONTHS OF start of classes	PLACEMENT DATE:	READ DATE:	RESULT: _____ MM INDURATION (IF NO INDURATION, RECORD 0)
	-OR-			
	Chest X-Ray IF STUDENT HAS A HISTORY OF A POSITIVE TB SKIN TEST OR TREATED TB DISEASE (MUST BE DONE IN THE USA WITHIN 1 YEAR OF REGISTRATION).	CHEST X-RAY DATE: <input type="checkbox"/> ATTACHED COPY OF CHEST X-RAY REPORT IN ENGLISH	QUANTIFERON GOLD/T-SPOT TEST DATE: RESULT: <input type="checkbox"/> ATTACHED COPY OF LAB TEST IN ENGLISH	

SIGNATURE OF HEALTH PROVIDER		DATE	CLINIC STAMP:
HEALTH PROVIDER NAME (PRINT)		ADDRESS	
TELEPHONE NUMBER		FAX NUMBER	

****SIGNING PROVIDER IS VERIFYING ALL DATES ARE ACCURATE****