# Immunization Form for Non-Medical Students

**Last Name:**

**First Name:**

**Mi:**

**Student ID (8-Digits):**

**Date of Birth:**

**Sex at Birth:**

- Female
- Male

**Phone Number:**

**E-Mail:**

**First Quarter Attending:**

- Autumn
- Winter
- Spring
- Summer

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**Below Sections to be Completed by a Health Provider. Dates should be formatted as MM/DD/YYYY.**

### MMR (Combined Measles, Mumps, Rubella)

- 2 doses required or individual vaccines as listed below.
- Students born on or before 1/1/57 do not have provide immunity for MMR.

<table>
<thead>
<tr>
<th>Dose #1 Date (On or after first birthday &amp; after 1/1/68):</th>
<th>Dose #2 Date (At least 28 days after first MMR dose):</th>
</tr>
</thead>
</table>

**OR**

### Measles (Rubeola)

2 doses required. Both must be done on or after first birthday, after 1/1/68, and at least 28 days apart.

Dose #1 Date:  
Dose #2 Date:  

**OR** Attach copy of lab report (titer) confirming immunity (antibodies)

### Mumps

2 doses required. Both must be done on or after first birthday, and at least 28 days apart.

Dose #1 Date:  
Dose #2 Date:  

**OR** Attach copy of lab report (titer) confirming immunity (antibodies)

### Rubella (German Measles)

2 doses required. Both must be done on or after first birthday, and at least 28 days apart.

Dose #1 Date:  
Dose #2 Date:  

**OR** Attach copy of lab report (titer) confirming immunity (antibodies)

### Tetanus/Diphtheria/Pertussis

3 doses of DTP, DPT, DTaP, DT, 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:  
DTP, DPT, DTaP, TD, DT, or Tdap Date:  

### Meningococcal Conjugate

- Required for all new students under the age of 22.
- One dose must have been given on or after 16th birthday.

Vaccine Date:  

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**Signature of Health Provider**  
**Signing provider is verifying all dates are accurate**  
**Date**

**Health Provider Name (Please print or use clinic stamp)**

**Address**

**Telephone Number**

**Fax Number**