



IMMUNIZATION FORM FOR NON-MEDICAL STUDENTS - 2026-27

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

BELOW SECTIONS TO BE COMPLETED BY A HEALTHCARE 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. - STUDENTS BORN ON OR BEFORE 1/1/57 DO NOT HAVE PROVIDE IMMUNITY FOR MMR.	DOSE #1 DATE (ON OR AFTER FIRST BIRTHDAY & AFTER 1/1/68):	DOSE #2 DATE (AT LEAST 28 DAYS AFTER FIRST MMR DOSE):		
	OR PROVIDE THE FOLLOWING:				
	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: <small>(PLEASE CIRCLE THE TYPE OF DOSE)</small>		DTP, DPT, DTaP, TD, DT, OR Tdap DATE: <small>(PLEASE CIRCLE THE TYPE OF DOSE)</small>		
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:		

SIGNATURE OF HEALTH PROVIDER ****SIGNING PROVIDER IS VERIFYING ALL DATES ARE ACCURATE**** DATE

HEALTHCARE PROVIDER NAME (PLEASE PRINT OR USE CLINIC STAMP) ADDRESS

TELEPHONE NUMBER FAX NUMBER