REQUIRED IMMUNIZATIONS

A. M.M.R. (MEASLES, MUMPS, RUBELLA)  (Two doses required at least 28 days apart for students born after 1956.)
1. Dose 1 given at age 12 months or later ........................................................................................................... #1  ___/___/___
   M      D      Y
2. Dose 2 given at least 28 days after first dose ................................................................................................................ #2  ___/___/___
   M      D      Y

B. TETANUS-DIPHTHERIA-PERTUSSIS  (Primary series AND booster within the last ten years. See ACIP for details)
1. Primary series of four or five doses with DTaP, DTP, DT, OR Td: .............................................. #1  ___/___/___ #2  ___/___/___ #3  ___/___/___ #4  ___/___/___ #5  ___/___/___
   M      D      Y
   M      D      Y
   M      D      Y
   M      D      Y
   M      D      Y
2. Booster within the last ten years: Tdap (Adacel or Boostrix) ................................................................. #2 ___/____/____
   M   D    Y
   M   D    Y

C. POLIO  (Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)
1. OPV alone (oral Sabin three doses): OPV #1___/___/___   OPV #2 ___/___/___   OPV #3___/___/____
   M      D      Y   M      D      Y   M      D      Y
2. IPV/OPV sequential:  IPV #1 ___/___/___   IPV #2 ____/____/____   OPV #3 ___/___/___   OPV #4 ___/___/___
   M      D      Y   M      D      Y   M      D      Y   M      D      Y
3. IPV alone (injected Salk four doses): IPV #1___/___/___   IPV #2 ___/___/___   IPV #3 ___/___/___   IPV #4 ___/___/___
   M      D      Y   M      D      Y   M      D      Y   M      D      Y

D. VARICELLA  (History of chicken pox, birth in the U.S. before 1980, a positive varicella antibody test OR two doses of vaccine.)
1. History of disease ................................................................................................................................. □ Yes OR □ No
   □ Yes □ No
   M      D      Y
2. Varicella antibody ................................................................................................................................. Date tested ___/___/___  Result: □ Reactive □ Non-Reactive
   M      D      Y
3. Immunization
   a. Dose #1 ................................................................................................................................. #1___/___/___
      M      D      Y
   b. Dose #2 given at least 4 weeks after first dose ........................................................................ #2 ___/___/___
      M      D      Y

E. HEPATITIS B  (Three doses of vaccine, OR two doses of adult vaccine in adolescents 11-15 years of age, OR a positive hepatitis B surface antibody meets the requirement.)
1. Immunization (hepatitis B) ...................................................................................................................... Dose #1___/___/___  Dose #2 ___/___/___  Dose #3 ___/___/___
    M      D      Y   M      D      Y   M      D      Y
   Adult formulation___   Adult formulation___   Adult formulation___
   Child formulation___   Child formulation___   Child formulation___
2. Immunization (Combined hepatitis A and B vaccine) ................................................................. Dose #1___/___/___  Dose #2 ___/___/___  Dose #3 ___/___/___
    M      D      Y   M      D      Y   M      D      Y
3. Hepatitis B surface antibody: ............................................................................................................... Date tested ___/___/___  Result □ Reactive □ Non-reactive
    M      D      Y

F. MENINGOCOCCAL QUADRIVALENT  (A,C,Y,W-135)  Two dose primary series (if started before age 16) or single dose (if given at or after age 16) for all first-year college students living in residence halls. All incoming college students age 21 or younger should have a dose no more than 5 years before enrollment. Other students under 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease, but vaccination is optional for these students. Quadrivalent polysaccharide vaccine is an acceptable alternative if conjugate vaccine is not available.
1. Quadrivalent meningococcal conjugate vaccine: ..................................................................................... #1 ___/___/___
   M      D      Y
2. Dose #2 (at least 8 weeks after first dose) if initial dose given before age 16, or for persons with ongoing risk: .... #2 ___/___/___
   M      D      Y

Please continue to page 2.
RECOMMENDED IMMUNIZATIONS

G. HUMAN PAPILLOMAVIRUS (For both males and females; Two doses of vaccine if started between 9-14 years of age, or three doses of vaccine if started between 15-26 years of age, at 0, 1-2, and 6 month intervals.)
Specify Quadrivalent (HPV4) ___ or 9-valent (HPV9) ____ Immunization Dates: #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

H. INFLUENZA Trivalent or quadrivalent inactivated influenza vaccine (TIV or QIV) or live attenuated influenza vaccine (LAIV).
Annual immunization recommended for all college students to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals.

Immunization ________________ Date __/___/___ Date __/___/___ Date __/___/___ Date __/___/___ Date __/___/___ Date __/___/___
(Most recent dose)

I. HEPATITIS A
1. Immunization Date (hepatitis A) ____________________________ #1 ___/___/___ #2 ___/___/___ or
2. Immunization Date (Combined hepatitis A and B vaccine) ____________________________ #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

J. MENINGOCOCCAL B VACCINE
Young adults aged 16-23 may be vaccinated with either a 2-dose series of Bexsero or a 2 or 3-dose series on Trumenba vaccine to provide short-term protection against most strains of serogroup B meningococcal disease. The same vaccine product must be used for all doses: Bexsero #1 ___/___/___ #2 ___/___/___ or Trumenba #1 ___/___/___ #2 ___/___/___ #3 ___/___/___

REQUIRED TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease? .......................................................... □ Yes □ No
   If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease.

2. Is the student a member of a high-risk group? (*) .......................................................... □ Yes □ No
   If No, stop. If Yes, place tuberculin skin test or draw blood for IGRA testing. A history of BCG vaccination should not preclude testing of a member of a high-risk group, but IGRA is preferred.

3. Tuberculin Skin Test: .................................................. Date Given: ____/____/____ Date Read: ____/____/____ Result: 
   TST interpretation (based on mm of induration and risk factors): .......................................................... □ Positive □ Negative

4. IGRA: .......................................................... Date: ___/___/___ Result: Negative □ Positive □ Indeterminate: □

5. Chest x-ray .......................................................... Date of chest x-ray: ___/___/___ Result: □ Normal □ Abnormal
   (required if TST or IGRA is positive)

(*) High risk groups include those students who were born in, or who have had frequent or prolonged visits to countries where TB is endemic. See World Health Organization Global Health Observatory, Tuberculosis Incidence, list of countries with incidence rates of ≥ 20 cases per 100,000 population. For current listing of such countries refer to http://apps.who.int/gho/data/node.main.1320
Other categories of high-risk students include those with recent close contact with someone with infectious tuberculosis; with HIV infection/AIDS; who inject drugs; who have resided in, volunteered in, or worked in high-risk congregate settings such as prisons, nursing homes, hospitals, residential facilities for patients with AIDS, or homeless shelters; and those who have clinical conditions such as diabetes, chronic renal failure, leukemia or lymphoma, low body weight, gastrectomy or jejunooileal by-pass, chronic malabsorption syndromes, prolonged corticosteroid therapy, immunosuppressive therapy or other immunosuppressive disorders.

HEALTHCARE PROVIDER NAME ____________________________
ADDRESS ____________________________________________________________________________________________
PHONE ___________________________________ FAX __________________________________
SIGNATURE __________________________________ DATE _________________________________