UNIVERSITY HEALTH CENTER
IMMUNIZATION VERIFICATION FORM

PRINT STUDENT NAME (LAST, FIRST, MI)   DATE OF BIRTH (MM/DD/YYYY)   CWID

GENERAL INSTRUCTIONS: This form must be completed, stamped and signed by your healthcare provider and mailed to our office after entering vaccine information into the MyHealth web portal.

FOR THE SAFETY OF OUR CAMPUS COMMUNITY, STUDENTS WHO DO NOT PROVIDE APPROPRIATE EVIDENCE OF IMMUNITY MAY BE REMOVED FROM CAMPUS DURING A COMMUNICABLE DISEASE OUTBREAK.

HEALTHCARE PROVIDER INSTRUCTIONS: Please complete this form and provide a copy of any antibody titer blood test results that demonstrate immunity to specific diseases.

MMR REQUIREMENT: (ALL DEGREE SEEKING STUDENTS) 2 doses Measles (Rubeola), 2 doses Mumps and 1 dose Rubella after first birthday or 2 doses MMR after first birthday or Positive (reactive) MMR titers confirming immunity. Dose 2 of all vaccines must be given at least 4 weeks after dose 1.

Measles-Mumps-Rubella (MMR) Vaccine:
Date for MMR dose 1: (must be after first birthday) __________ Date for MMR dose 2: __________
-OR-
Individual Measles, Mumps, Rubella Vaccine:
Date for Measles dose 1: (must be after first birthday) __________ Date for Measles dose 2: __________
Date for Mumps dose 1: (must be after first birthday) __________ Date for Mumps dose 2: __________
Date for Rubella dose 1: (must be after first birthday) __________
-OR-
MMR TITERS (Equivocal results are not accepted. Results must be POSITIVE or NEGATIVE and accompanied by a copy of blood test results. Please note that ONLY positive (reactive) titers satisfy the requirement.)
Date for Measles titer confirming immunity: __________ Result (circle one): POSITIVE NEGATIVE
Date for Mumps titer confirming immunity: __________ Result (circle one): POSITIVE NEGATIVE
Date for Rubella titer confirming immunity: __________ Result (circle one): POSITIVE NEGATIVE

HEPATITIS B REQUIREMENT: ALL FULL-TIME, DEGREE SEEKING STUDENTS
Date for dose 1: __________ Date for dose 2: __________ Date for dose 3: __________
Dose 2 must be at least 4 weeks after dose 1. Dose 3 must be at least 16 weeks after dose 1 and 8 weeks after dose 2.

MENINGITIS REQUIREMENT: ALL STUDENTS RESIDING IN UNIVERSITY HOUSING ONLY. One dose of MCV4 – Meningococcal conjugate serogroups A, C, W and Y on or after 16th birthday is required for students living in University Housing. Common U.S. names for this vaccine are Menveo and Menactra.
Date of last Meningococcal (MCV4) Vaccine: __________

The following vaccinations are strongly recommended:

BEXSERO Meningococcal B Vaccine: Serogroup B
Date for dose 1: __________ Date for dose 2: __________
- OR –
TRUMENBA Meningococcal B Vaccine: Serogroup B [Can be given in a 2 or 3 dose schedule]
Date for dose 1: __________ Date for dose 2: __________ Date for dose 3: __________
<table>
<thead>
<tr>
<th>Vaccine Type</th>
<th>Date of Dose 1</th>
<th>Date of Dose 2</th>
<th>Date of Dose 3</th>
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<tbody>
<tr>
<td>Varicella (Chickenpox) Vaccine</td>
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<tr>
<td>Tdap (tetanus, diphtheria and pertussis) Vaccine</td>
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<td>Td (tetanus, diphtheria) Vaccine</td>
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<tr>
<td>Hepatitis A (Hep A) Vaccine</td>
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<td>CERVARIX Human Papilloma (HPV) Vaccine</td>
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<td>GARDASIL Human Papilloma (HPV) Vaccine</td>
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<td>GARDASIL-9 HUMAN PAPILLOMA (HPV) VACCINE</td>
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<td>Pneumococcal Vaccine 13-Valent</td>
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<tr>
<td>Pneumococcal Vaccine 23-Valent</td>
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</tbody>
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**TST/PPD (Mantoux):**
- Date: ________
- Reaction: _____
- Negative _____
- Positive _____
- Induration _____ mm

**Chest X-ray:**
- Date: ________
- Result: __________________________

**INH Therapy:**
- Start Date: ________
- Stop Date: ________

**HEALTHCARE PROVIDER NAME (please print):**

**Signature:**

**Address:**

**Phone:**

**Date:**

**Organizational Stamp:**

**Provider:** Please provide completed form and copy of antibody titer blood tests.