

Immunization History Form

Student's Name: (last) _____ (first) _____	Date of birth: _____
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CWID: _____	Student Cell Phone # _____
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REQUIRED - Measles, Mumps, Rubella

MMR (2-dose series): Dose 1: ___/___/___ (Must be on or after 1st birthday) Dose 2: ___/___/___	Measles: 1: ___/___/___ 2: ___/___/___ Mumps: 1: ___/___/___ 2: ___/___/___ Rubella: ___/___/___	MMR Antibodies (IgG) (within 10 years) Result Date: ___/___/___ OR A copy of the lab report is <u>REQUIRED</u> . If non-immune, the state requires you to receive the appropriate vaccination(s).
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REQUIRED for full time- Hepatitis B

Hepatitis B (3-dose series): Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3: ___/___/___ Dose 4: ___/___/___	Hepatitis B (2-dose series): Dose 1: ___/___/___ Dose 2: ___/___/___	Hepatitis B Surface Antibody (HBsAb) (within 10 years) Result Date: ___/___/___ OR A copy of the lab report is <u>REQUIRED</u> . If non-immune, the state requires you to receive the appropriate vaccination(s).
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REQUIRED - Meningococcal-ACYW Dose 1: ___/___/___ Dose 2: ___/___/___

ONE dose must be given at age **16 or older** AND IF you're a new residential student, your last dose must be within 5 years.

Meningococcal-B REQUIRED for at risk individuals
 (including asplenia, sickle cell, complement deficiency or complement inhibitor use, HIV or N. meningitidis lab work)

Dose 1: ___/___/___ Dose 2: ___/___/___ Dose 3: ___/___/___ Bexsero Trumenba

TB Testing REQUIRED for All International Students

PPD (Mantoux) Skin Test (within 6 months) Administer Date: ___/___/___ Result Date: ___/___/___ Negative <input type="checkbox"/> Positive <input type="checkbox"/> Induration (mm): _____	OR QFT-G or T-Spot results are accepted A copy of the lab report is <u>REQUIRED</u> * A positive result requires a recent chest x-ray.
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Recommended Vaccines		HPV	Hepatitis A	Varicella	Tdap
	1				
	2				
	3				

Healthcare Provider Name (please print): _____ Signature: _____ Date: _____	Healthcare Provider Stamp
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