

PART IV STUDENT IMMUNIZATION RECORD | Please have the following form completed, signed and stamped your healthcare provider OR LEAVE BLANK and submit all requirements listed below on the original forms from the clinic or provider you received them at.

Last Name: _____		First Name: _____		Date of Birth: ____/____/____	
Measles, Mumps and Rubella (MMR): Positive QUANTITATIVE IgG antibody titers are required for Mumps, Measles and Rubella. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.					
MMR Titer Dates: Measles Titer: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune Mumps Titer: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune Rubella Titer: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Attach copy of quantitative titer report		MMR 2 Vaccine Series (Optional): 1). ____/____/____ 2). ____/____/____		If Non-immune titer- two-vaccine Series after titer: 1). ____/____/____ 2). ____/____/____ *Submit repeat Quantitative Titer report from the lab 6 weeks after booster.	
Varicella (Chicken Pox): Positive QUANTITATIVE IgG antibody titer is required. If a titer results in non-immunity a two-vaccine series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.					
Varicella Titer Date: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Attach copy of quantitative titer report		Varicella 2 Vaccine Series (Optional): 1). ____/____/____ 2). ____/____/____		If Non-immune titer- two-vaccine Series after titer: 1). ____/____/____ 2). ____/____/____ *Submit repeat Quantitative Titer report from the lab 6 weeks after 2 doses.	
Hepatitis B: Positive QUANTITATIVE IgG antibody titer is required *If a titer results in non-immunity an additional three vaccine series or Heplisav-B two dose series and follow-up titer must be completed. *Titers must include numerical result and or numerical reference ranges.					
HepB Titer Date: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Attach copy of quantitative titer report		HepB Vaccine Series (Optional): 1). ____/____/____ 2). ____/____/____ 3). ____/____/____ Heplisav- B Vaccine Series (Optional): 1). ____/____/____ 2). ____/____/____		If non-immune titer -Repeat full vaccine Series: 1). ____/____/____ 2). ____/____/____ 3). ____/____/____ <input type="checkbox"/> Energix-B <input type="checkbox"/> Heplisav-B *Submit repeat Quantitative Titer report from the lab 6 weeks after final dose in new series is completed.	
Influenza Vaccine (Flu): Required seasonally, typically by September 30 th each year. Declinations are NOT accepted.					
Flu Vaccine Date: ____/____/____					
Tetanus Diphtheria, Pertussis (Tdap): Tdap vaccine within the past ten years is required. TD booster is accepted ONLY IF TDAP ON FILE.					
Tdap Vaccine Date: ____/____/____ Lot # ____ Exp ____		TD Booster (Tdap must be documented): ____/____/____			
Meningococcal (Meningitis): Vaccine must be within past five years for anyone 22 or younger.					
Meningococcal Vaccine Date: ____/____/____					
Polio Myelitis (Polio): Primary vaccine series dates (IPV or OPV) OR one booster date is accepted if dated after 1988.					
IPV or OPV: 1). ____/____/____ 2). ____/____/____ 3). ____/____/____ OR Polio Booster After 1988: ____/____/____ OR Polio Titer: ____/____/____ Result: <input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune					
Tuberculosis Skin Test (PPD/Mantoux): A negative PPD skin test within 12 months OR negative TB Blood test (QuantiFERON or T-spot) within 12 months of the 1 st day of class. Annual update required. *If POSITIVE: a Chest X-ray with NEGATIVE results is required. Students with a POSITIVE TB test and NEGATIVE Chest X-ray will also be counseled regarding latent TB and required to comply with Direct Observational Therapy according to CDC guidelines.					
TB Skin Plant Date: ____/____/____ TB Skin Read Date: ____/____/____ Result: ____ mm <input type="checkbox"/> Neg <input type="checkbox"/> Pos OR QuantiFERON TB Gold Date: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos OR T-Spot Date: ____/____/____ <input type="checkbox"/> Neg <input type="checkbox"/> Pos		If positive TB; Chest X-Ray Date: ____/____/____ Result: ____ mm <input type="checkbox"/> Neg <input type="checkbox"/> Pos			
Primary Care Provider Signature AND Provider's stamp is required for immunizations on this form to be accepted. _____ PLACE PROVIDER'S STAMP HERE					
Provider's Signature _____		Date _____			
Provider Name (printed): _____ Phone Number: (____) _____					