REQUIRED IMMUNIZATIONS

A. M.M.R. (MEASLES, MUMPS, RUBELLA) (Two doses required at least 28 days apart, given after 12 months of age)
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 / / M D Y
   #2 / / M D Y #3 / / M D Y #4 / / M D Y #5 / / M D Y
2. Booster within the last ten years: Tdap (Adacel or Boostrix)
   (specify type) OR Td (Decavac)

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 / / M D Y
   OPV #2 / / M D Y OPV #3 / / M D Y
2. IPV/OPV sequential: IPV #1 / / M D Y
   IPV #2 / / M D Y OPV #3 / / M D Y OPV #4 / / M D Y
3. IPV alone (injected Salk four doses): IPV #1 / / M D Y
   IPV #2 / / M D Y IPV #3 / / M D Y IPV #4 / / 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 .................................................................................................................................................. #1 / / M D Y
   □ Yes OR ...........................................Birth in U.S. before 1980? □ Yes
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 12 weeks apart if vaccinated between ages 1 and 12, or 4 weeks apart if age 13 or older #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) .................................................................................................................................. #1 / / M D Y
   Adult formulation ___ Child formulation ___
   Dose #2 / / M D Y Dose #3 / / M D Y
   Adult formulation ___ Child formulation ___
2. Immunization (Combined hepatitis A and B vaccine)......................................................................................... Dose #1 / / M D Y
   Dose #2 / / M D Y Dose #3 / / M D Y
   Adult formulation ___ Child formulation ___
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
   living in campus housing should have a dose no more than 5 years before enrollment. For all other students vaccination is optional.
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. SARS-CoV-2 (COVID-19) VACCINE

Dose #1: Product Name/Manufacturer ____________________________ Date ___/___/___

Dose #2: Product Name/Manufacturer ____________________________ Date ___/___/___

Additional Dose: Product Name/Manufacturer ____________________________ Date ___/___/___

Additional Dose: Product Name/Manufacturer ____________________________ Date ___/___/___

H. 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 9-valent (HPV9) ______ or other ______

I. INFLUENZA

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 ___/___/___

(Most recent dose)

J. HEPATITIS A

1. Immunization Date (hepatitis A) .......................................................... #1 ___/___/___ #2 ___/___/___

or

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

K. SEROGRUP B MENINGOCOCCAL 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 ___/___/___

L. PNEUMOCOCCAL VACCINE

• Adults age 19 through 64 with certain chronic medical conditions (diabetes, chronic heart, lung or liver disease, alcoholism, cigarette smoking) and adults age 65 and older: one dose of PPSV23.

• Age 19 and older with immunocompromising conditions or medications, chronic renal failure, malignancy, solid organ transplant, sickle cell disease, no spleen: one dose of PCV13 followed by one dose of PPSV23 at least 8 weeks later, repeated after 5 years.

• Age 19 and older with cerebrospinal fluid leak or cochlear implant: one dose of PCV13 followed by one dose of PPSV23 at least 8 weeks later.

Immunization Type ............... Date ___/___/___ Date ___/___/___ Date ___/___/___ Date ___/___/___

HEALTHCARE PROVIDER NAME ___________________________________________________________

ADDRESS _____________________________________________________________________________

PHONE ____________________________ FAX ___________

SIGNATURE ____________________________ DATE ____________________________

(Rev. 2/23)