Return by July 31st to:
Student Health Center
204 W. Washington Street
Lexington, VA 24450
Fax: (540) 458-8404
studenthealth@wlu.edu
Phone: (540) 458-8401

WASHINGTON AND LEE UNIVERSITY

Lexington, Virginia 24450-2116

IMMUNIZATION RECORD

This form is to be completed and signed by your healthcare provider

STUDENT'S LAST NAME (Print) _____ FIRST NAME _____ MIDDLE _____ DATE OF BIRTH: ___/___/___ (M D Y)

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) ___/___/___ (M D Y)

(specify type) OR Td (Decavac) ___/___/___ (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 ___/___/___ (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 ..... ☐ Yes **OR** .....Birth in U.S. before 1980? ☐ Yes
2. Varicella antibody ..... Date tested ___/___/___ (M D Y) Result: ☐ Reactive ☐ Non-Reactive
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).....Dose #1 ___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (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 ___/___/___ (M D Y) Dose #2 ___/___/___ (M D Y) Dose #3 ___/___/___ (M D Y)
3. Hepatitis B surface antibody: .....Date tested ___/___/___ (M D Y) Result ☐ Reactive ☐ Non-reactive

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.

STUDENT'S LAST NAME (Print) FIRST NAME MIDDLE DATE OF BIRTH: M D Y

G. SARS-CoV-2 (COVID-19) VACCINE

All students must be Fully Vaccinated (completed primary series) and Up to Date (has received all recommended booster dose(s) when eligible) with an FDA or WHO authorized COVID-19 vaccine. Single dose or two dose primary series and timing between doses is based on which vaccine is received. Please attach a copy of your COVID-19 Vaccination Card(s). Contact the Student Health Center to request specific medical or religious exemption forms for COVID-19 primary vaccination or booster.

Dose #1: Product Name/Manufacturer_____ Date___/___/___ (M D Y)

Dose #2: Product Name/Manufacturer_____ Date___/___/___ (M D Y)

Additional Dose: Product Name/Manufacturer_____ Date___/___/___ (M D Y)

Additional Dose: Product Name/Manufacturer_____ Date___/___/___ (M D Y)

RECOMMENDED IMMUNIZATIONS

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 _____ Immunization Dates: #1___/___/___ #2___/___/___ #3___/___/___ (M D Y)

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___/___/___ (M D Y) (Most recent dose) Date___/___/___ (M D Y) Date ___/___/___ (M D Y) Date___/___/___ (M D Y) Date___/___/___ (M D Y)

J. HEPATITIS A

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

or

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

K. SEROGROUP 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___/___/___ (M D Y) or Trumenba #1___/___/___ #2___/___/___ #3___/___/___ (M D Y)

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___/___/___ (M D Y) Type_____ Date___/___/___ (M D Y) Type_____ Date ___/___/___ (M D Y)

HEALTHCARE PROVIDER NAME _____

ADDRESS _____

_____

PHONE_____ FAX_____

SIGNATURE_____ DATE _____