Student Printed Name: _____ **Student ID Number:**_____

A complete immunization record from a physician or clinic may be attached to this form.

IMMUNIZATION RECORD	(Please print in black ink) To be completed and signed by physician or clinic. A complete immunization record from a physician or clinic may be attached to this form.			
	Date	Date	Date	Date
• DTP or Td	(#1)	(#2)	(#3)	(#4)
• Tdap within 10 years				
• Polio				
• MMR (after first birthday)				
• MR (after first birthday)				
• Measles (after first birthday)			***(Disease Date NOT Accepted)	****Titer Date & Result
• Mumps			***(Disease Date NOT Accepted)	****Titer Date & Result
• Rubella			***(Disease Date NOT Accepted)	****Titer Date & Result
• Hepatitis B Series/Titer	(#1)	(#2)	(#3)	****Titer Date & Result
• Varicella (Chicken pox) series of two doses or positive titer after the two doses. • May have positive immunity by titer due to disease even if no vaccine • Disease Date not Accepted; positive titer without Vaccination accepted			***(Disease Date NOT Accepted)	****Titer Date & Result
• Tuberculin (TST) Test (within 3 months of start of clinical) Skin test May 1-July 31for Aug 1 start date)	Date Read	mm induration		
• Chest x-ray, if positive TST; annual surveillance form	Date			
• Influenza (Required annually during flu season with due date announced each Fall Semester)	Date			

Signature or Clinic Stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner **Date**

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner **Area Code/Phone Number**

_____

Office Address **City** **State Zip Code**

** Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age.
*** Only laboratory proof of immunity is acceptable, not history of disease, if the vaccine is not taken.
**** Attach Lab report