Student Name: _____ Date of Birth: _____

To be filled out by student's primary health provider or provide copies of physician documented immunization records.

Required Immunizations:

MMR (Measles, Mumps, Rubella) List two dates of vaccination:

1._____ 2._____

Two doses* (The 1st dose administered after the student's first birthday and the 2nd dose administered at least 1 month after the 1st dose)

OR

Measles 1._____ 2._____ **Mumps**_____ **Rubella** _____

Two doses* (as above) One dose after 1st birthday One dose after 1st birthday

OR

Date and result of blood test – demonstration of immunity

To **Measles** _____ **Mumps** _____ **Rubella** _____

Recommended Vaccines:

Meningitis Menactra _____ Menomune_____

M/D/Y M/D/Y

If student refuses the meningitis vaccine direct them to the Meningitis Response Form on the front of their Health Report packet

Tetanus/Diphtheria within 10 years prior to registration Td _____ **or** Tdap _____

M/D/Y M/D/Y

Polio 3 doses minimum to complete series □ Complete □ Incomplete

Hepatitis B 3 doses _____ _____ _____

M/D/Y M/D/Y M/D/Y

Varicella 2 doses _____ _____

M/D/Y M/D/Y

HPV Vaccine 3 doses _____ _____ _____

M/D/Y M/D/Y M/D/Y

Hepatits A 2 doses _____ _____

M/D/Y M/D/Y

PPD (within 6 months if indicated, please refer to the Tuberculosis Screening sheet included with this form for indications)

Date Given: _____ Date Read:_____

M/D/Y M/D/Y

Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")

Chest x-ray (required if tuberculin skin test is positive) Result: □ Normal □ Abnormal

Please submit copy of written chest x-ray report to Student Health Service.

Provider Name: _____ **Signature:** _____