



IMMUNIZATION RECORD

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

OR YOU CAN SUBMIT A SIGNED IMMUNIZATION RECORD FROM YOUR PRIMARY CARE PROVIDER.

**STUDENTS WHO FAIL TO PROVIDE PROOF OF THE REQUIRED IMMUNIZATIONS
WILL NOT BE PERMITTED TO REGISTER FOR CLASSES.**

Please print :Last Name: _____ First Name: _____ Date of Birth: _____

REQUIRED

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required at least one month apart or positive immune titer verifying immunity.

MMR Dose 1 ___/___/___ Dose 2 ___/___/___ OR Positive Titer ___/___/___

- **HEPATITIS B:** Three doses (doses one and two given four weeks apart and the third dose should be at least four months after first dose) or positive immune titer verifying immunity.

Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___ OR Positive Titer ___/___/___

- **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap):** Tdap ___/___/___ Td ___/___/___ *

* Tetanus/diphtheria (Td) booster within the last 10 years.

- **MENINGOCOCCAL VACCINE: (MCV4)** Dose 1 ___/___/___ Dose 2 * ___/___/___

* Required if under 22 years old. If you were vaccinated prior to your 16th birthday, a booster dose (Dose #2) is also required.

- **VARICELLA:** Two doses of chicken pox vaccine are required at least one month apart or positive immune titer verifying immunity or medical provider’s documented history of disease.

Dose 1 ___/___/___ Dose 2 ___/___/___ OR Positive titer ___/___/___ OR Disease History ___/___/___

OTHER

- **SEASONAL FLU:** ___/___/___

- **HEPATITIS A:** Dose 1 ___/___/___ Dose 2 ___/___/___

- **HUMAN PAPILOMAVIRUS VACCINE (HPV):** Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

- **MENINGOCOCCAL SEROGROUP B: *** Dose 1 ___/___/___ Dose 2 ___/___/___ Dose 3 ___/___/___

* This is not the same as Meningococcal (MCV4)

- **OTHER IMMUNIZATIONS:** _____

- **MEDICAL/RELIGIOUS EXEMPTION:** Yes * Exemption Certificate Required

Health Care Provider: _____ Date: _____

Signature and Title: _____ Office Phone: _____