



**IMMUNIZATION
RECORD**

Name: _____
 Date of Birth: ____/____/____ Age: ____
 Univesal ID: 000 _____
 Residency: ____ Resident (on-campus) ____ Commuter (off-campus)
 D/I: ____ Domestic Student ____ International Student

SECTION A: Required Immunizations

	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (must include lab report)
1. MMR (Measles, Mumps, Rubella)			NOT APPLICABLE	OR
2. Hepatitis B (OR Complete the waiver below)				OR

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Hepatitis B Waiver (Only complete if you are declining this vaccine)

I have received the required information regarding the risk of acquiring Hepatitis B and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by checking the box and signing below. I understand that declining this vaccine series now does not mean I may not receive them in the future.

 Student or Parent/Guardian Signature (if student is under the age of 18)

 Date

**3. MCV4/MenACWY (Menveo/MenQuadfi) or
MenACBWY (Penbraya)**

(OR Commuters may complete the waiver below)

NOT APPLICABLE

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Meningitis ACWY Waiver for Commuter Students (Only complete if you are declining this vaccine)

I have received the required information regarding the risk of acquiring Meningococcal Meningitis and the benefits of receiving immunizations to reduce those risks. I also understand that I am required to receive these immunizations or to actively decline the immunizations by checking the box and signing below. I understand that declining this vaccine series now does not mean I may not receive them in the future.

 Student or Parent/Guardian Signature (if student is under the age of 18)

 Date

4. Tuberculosis Screening (Required for International Students. Must be completed within the 12 months prior to start of classes.)

TB Skin Test by TST (Mantoux)	Date Placed	Date Read	Induration of millimeters _____ mm	Result (circle one) Negative / Positive
OR Interferon-based Assay (QFT or Tspot)	Date	Result	Required: Submit copy of lab report in English	
Chest X-ray (Only if positive TST or Lab Test)	Date	Result	Required: Submit copy of lab report in English	

SECTION B: Recommended Immunizations (Not Required for Matriculation)

Td		NOT APPLICABLE		
Tdap (Adacel/Boostrix)		NOT APPLICABLE		
Varicella (Chickenpox)			NOT APPLICABLE	
Hepatitis A				
HPV (Gardasil or Cervarix)				NOT APPLICABLE
Meningitis B	Bexsero		NOT APPLICABLE	
	Trumenba			NOT APPLICABLE
	Penbraya		NOT APPLICABLE	

An official stamp from a medical provider, clinic or health department AND an authorized signature must appear here or this form will not be approved. You must attach a State Immunization Form if this section is blank.

 Official Office Stamp Here

 Physician or Authorized Signature

 Date