Immunization Record

Peace College Wellness Center

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.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	Social Security Number

Provision of social security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide personal identifier information for the internal records of this institution.

SECTION A: REQUIRED IMMUNIZATIONS	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DTP or Td				
Tdap (if not received within last 10 years)				
Polio				
MMR (after first birthday) 2 doses required				
*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 (Required for students born in 1994 or after)				*** Titer Date & Result
Tuberculin (PPD) (within 12 months)	Date Read	MM	Induration	
Chest x-ray, if positive PPD	Date	Results		
Treatment if applicable	Date	Results		

SECTION B: RECOMMENDED IMMUNIZATIONS: The following immunizations are recommended for all students and may be required by certain departments. Please consult your department materials for specific requirements.

Meningococcal	Received the meningococcal vaccine?		No	Yes
If yes, please indicate dates (s) vaccine was received (mo/day/year):				
	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
Varicella (chicken pox) series of 2 doses or immunity by positive blood titer			Disease Date	*** Titer Date & Result

SECTION C: OPTIONAL IMMUNIZATIONS:	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
Haemophilus influenzae type B (HIB)				
Quadrivalent Human Papillomavirus Vaccine (HPV)				
Pneumococcal				
Hepatitis A series only				
Other				

* Rubeola (measles) vaccine must be repeated if received even one day prior to 12 months of age. History and date of physician diagnosed measles is acceptable, but physician must provide a signed statement.

** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

*** Attach lab report.

Signature of Clinic Stamp REQUIRED:

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

Print Name of Physician/Physician Assistant/Nurse Practitioner _____

Office Address _____ City _____ State _____ Zip Code _____