IMMUNIZATION RECORD

NAME OF STUDENT_____

Please note: All immunizations and/or lab serology tests are required unless otherwise noted. This record must be completed by your physician or medical provider. All immunizations must be verified by the signature and office stamp of your physician or medical provider below. You may submit copies of immunization records and lab/serology test as proof of vaccine, history of disease or immunity.

Please make copies of this record for your personal records

REQUIRED VACCINES — MONTH/DAY/YEAR

A. MENACTRA VACCINE A/C/Y/3-135 (REQUIRED) — _____/___/_____
VACCINE AGAINST NEISERRIA MENINGITIS

B. VARICELLA VACCINE (2 doses required)
VACCINE AGAINST CHICKENPOX DISEASE
☐ First vaccine (Required) _____/___/_____
☐ Second vaccine (Required: due 4 weeks after first vaccine) _____/___/_____
Other Means of Obtaining Proof of Immunity
☐ Student had disease (chickenpox or shingles confirmed by MD's records) _____/___/_____
☐ Laboratory/serology test for evidence of immunity: _____/___/_____
(Obtain if uncertain about dates of vaccine disease) ☐Reactive ☐Non-reactive
Note: If the test is NON-REACTIVE, you MUST receive the Varicella vaccines

C. HEPATITIS VACCINE (3 doses required)
VACCINE AGAINST HEPATITIS B DISEASE
☐ First vaccine _____/___/_____
☐ Second vaccine (due 4 weeks after first vaccine) _____/___/_____
☐ Third vaccine (due 6 months after second vaccine) _____/___/_____
Other Means of Obtaining Proof of Immunity
☐ Laboratory/serology test for Hepatitis B surface antigen antibody: _____/___/_____
(Obtain if uncertain about dates of your Hepatitis B vaccines) ☐Reactive ☐Non-reactive
Note: If the test is NON-REACTIVE, you MUST receive the Hepatitis B vaccines.

D. M.M.R. (2 doses required)
VACCINE AGAINST MEASLES, MUMPS AND RUBELLA
☐ First vaccine should be given 12-15 months _____/___/_____
☐ Second vaccine should be given 4-6 years or after _____/___/_____
☐ Student born before 1957 is considered immune. <Date of Birth> _____/___/_____
Other Means of Obtaining Proof of Immunity
☐ Laboratory/serology test for evidence of immunity: _____/___/_____
(Obtain if uncertain about dates of vaccine or disease)
Note: If the test is NON-REACTIVE, you MUST receive the MMR vaccines.

E TETANUS, DIPHTHERIA (Tdap) or (Td) — _____/___/_____
VACCINE TO PREVENT "LOCKJAW"
Tetanus/diphtheria containing booster dose within the last 10 years.

HEALTH CARE PROVIDER
Please stamp with office stamp to verify you have reviewed and/or administered any or all immunizations
(Office Stamp Here)

Provider_____
Name (please print) Signature and Title