Patient name _____ DOB _____

Immunization History (Signed by MD, PA, DO, NP Only)

You must either: **1) Enter and upload documentation to Student Health Portal**: your childhood immunization records, vaccine (yellow) card, hospital or physician's records, lab reports **OR**

2) Have your healthcare provider (***physician, physician assistant, or nurse practitioner***) verify dates and results from your records, fill out and sign this form and **upload to Student Health Portal**

Any blood work done for titers/antibodies must show positive immunity; otherwise, entire vaccine series must be repeated/completed *(not just a booster).* **All dates must be in MM/DD/YYYY format**

Health Requirement	Dates (MM/DD/YYYY)	Result / Immunity	Notes
FLU VACCINE (Seasonal)	**Date:** _____		*Required every flu season*
Tdap (Td will not be accepted) (Tetanus, Diphtheria, Petussis)	**Date:** _____		*Within last 10 years from program start date*
HEPATITIS B Vaccines *(3 doses)*	**1.** _____ **2.** _____ **3.** _____		
or Hepatitis B sAb Titer	Date: _____	☐ Pos. ☐ Neg.	☐ Equivocal *If negative or equivocal, need to repeat 3 doses of vaccines.*
MMR—MEASLES, MUMPS, RUBELLA Vaccines *(1 or 2 doses, see note)*	1. _____ 2. _____		*(no age exception due to health science institution)*
or Rubeola IgG Titer	Date: _____	☐ Pos. ☐ Neg.	☐ Equivocal
Rubella IgG Titer	Date: _____	☐ Pos. ☐ Neg.	☐ Equivocal *If any are negative or equivocal, need to repeat 2 doses of vaccine*
Mumps IgG Titer	Date: _____	☐ Pos. ☐ Neg.	☐ Equivocal
VARICELLA Vaccines *(2 doses)*	1. _____ 2. _____		*History of Varicella does not fulfill this requirement. If you had the chickenpox, have your titer checked*
or Varicella Zoster IgG Titer	Dates: _____	☐ Pos. ☐ Neg.	☐ Equivocal *If negative or equivocal, need 2 doses of vaccines.*
PPD—TB SKIN TEST	1st step Date Placed _____ Read _____	☐ Pos. ☐ Neg.	Induration (mm): _____
Negative 2-step PPD*			**PPDs must be done within 6 months before program start date**
***A two-step PPD is two separate PPD placements; within 1-3 weeks apart.**	2nd step Date Placed _____ Read _____	☐ Pos. ☐ Neg.	Induration (mm): _____
OR **Quantiferon-TB Gold**	Date: _____	☐ Pos. ☐ Neg.	***Quantiferon-TB Gold must be done within 6 months before Program start date***
OR **Positive PPD History** Chest X-Ray	Date: _____	Result _____	***X-ray within 12 mos. before Program start date*** ***Student must fill out Tuberculosis Screening Survey***

I have verified all dates and results, and certify them to be correct to the best of my knowledge.

Date signed _____

Clinician Signature _____

Print Name and Title _____

Address _____

City/ State/ Zip _____

Telephone _____

Office Stamp Required

Samuel Merritt University