# Immunization Record

**NOT CONFIDENTIAL**

Immunization records are not confidential as required by law

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**Name:** ______________________________________________________________________

- Male
- Female

**Last**

**First**

**Middle**

**Social Security Number / FDU ID:**  |  |  |  - |  |  |  - |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

**Date of Birth:**  |  |  |  - |  |  |  - |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

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**TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER, GIVE MONTH, DAY & YEAR**

If convenient, you may attach a signed copy of your immunization records, which must include all previous and recent shots

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## 1. MEASLES, MUMPS, RUBELLA & MENINGITIS COMPLIANCE

<table>
<thead>
<tr>
<th>Immunization</th>
<th>#1</th>
<th>#2</th>
<th>Titers (Attach Lab Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

*Note: Measles has to be live, after 1st Birthday

**Meningitis** (Menomune® A/C/Y/W – 135, Meningococcal Polysaccharide Vaccine): Date [___] [___] [___] [___]

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## 2. TUBERCULOSIS TEST (Mantoux/PPD within past 6 months, regardless of prior BCG inoculation)

- **Mantoux Implant:** [____] [____] [____] [____] Read [____] [____] [____] [____] Result
  - Negative
  - Positive

**Size mm**

**Result**

(Induration)

If Mantoux (PPD) is Positive, Chest X-ray and a discussion of Chemoprophylaxis is required:

- **Chest X-ray** Date [____] [____] [____] [____]
- **Result**

(Attach Radiologist’s report)

**Chemoprophylaxis** Discussed on [____] [____] [____] [____]

**Treatment**

- INH
- Other (Name of Drug)

**Date Initiated** [____] [____] [____] [____]

**Dosage**

**Duration**

**International Students:**

- **BCG**
  - No
  - Yes [ Date Received: [____] [____] [____] ]

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## 3. CHILDHOOD IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization</th>
<th>#1</th>
<th>#2</th>
<th>#3</th>
<th>#4</th>
<th>#5</th>
<th>(Attach Lab Report)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diphtheria, Pertussis and Tetanus (DPT)</strong></td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td></td>
</tr>
</tbody>
</table>
| **Tetanus, Diphtheria (Td)** [within last 10 years] | [____] [____] [____] | [____] [____] [____] | [____] [____] [____] | (Tetanus Toxoid Not Acceptable)
| **Polio** | [____] [____] [____] | [____] [____] [____] | [____] [____] [____] | [____] [____] [____] | [____] [____] [____] | |

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<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td><strong>Hepatitis A</strong></td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td></td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
</tr>
<tr>
<td><strong>Varicella (Chicken Pox) Vaccine</strong></td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
<td>[<strong><strong>] [</strong></strong>] [____]</td>
</tr>
</tbody>
</table>

**and/or Titer Date** [____] [____] [____] [____]  
**Immune**

**Non-immune**

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**Signature of Medical Provider:** _______________________________  **Date:** ________________

**Medical Provider:** _______________________________  **Phone:** (          ) ____________

**Address:** ______________________________________________________________________

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**Remember! Proof of Immunity is required prior to registration.**

You will be put on medical hold unless you meet all entrance requirements.