CLARK UNIVERSITY MEDICAL RECORD

PART B - IMMUNIZATION RECORD

Immunity is required prior to registration. Please complete and return this form.

PART I - TO BE COMPLETED BY STUDENT

Name: _____ (Last) _____ (First) _____ (M.I.)

Date of Birth: ___ ___ ___ (Month Day Year) Social Security Number: ___ – ___ – ___

Status: **Undergraduate:** ☐ Freshman ☐ Sophomore ☐ Junior ☐ Senior

PART II - TO BE COMPLETED BY HEALTH PROVIDER (Dates must include month, day and year)

REQUIRED

A. TETANUS-DIPHTHERIA

- ☐ Td (tetanus-diphtheria booster) within the last ten (10) years. ___ ___ ___ (Month Day Year)
- ☐ Tdap (a one-time dose of Tdap is recommended if at least two to five years since last Td) ___ ___ ___ (Month Day Year)

B. M.M.R. (Measles, Mumps, Rubella)

- ☐ Dose 1 - Immunized on or after 1st birthday. ___ ___ ___ (Month Day Year)
- ☐ Dose 2 - Immunized at least one month after Dose 1 ___ ___ ___ (Month Day Year)

Two doses required or lab test proving immunity (attach lab reports)

Measles: ☐ Immune - Attach Lab Report ___ ___ ___ (Month Day Year)

Mumps: ☐ Immune - Attach Lab Report ___ ___ ___ (Month Day Year)

Rubellas: ☐ Immune - Attach Lab Report ___ ___ ___ (Month Day Year)

C. HEPATITIS B VACCINE

Vaccine Dates

- ☐ Dose 1 ___ ___ ___ (Month Day Year)
- ☐ Dose 2 ___ ___ ___ (Month Day Year)
- ☐ Dose 3 ___ ___ ___ (Month Day Year)

OR

___ ___ ___ (Month Day Year)

- ☐ Hepatitis B surface antibody (**only HBsAB is acceptable**). Attach copy of dated lab report.

REQUIRED

D. TUBERCULOSIS: PPD (Mantoux) test within the past year if high risk.
Risk Assessment: Must complete tuberculosis questionnaire on next page to determine risk.

- ☐ Low Risk. **PPD not required.**
- ☐ High Risk. **PPD required** regardless of prior BCG inoculation. ___ ___ ___ (Month Day Year)
  Must complete section below.
  - ☐ PPD Planted
  - ☐ Result _____mm

Note: If PPD is positive, complete section below.

1. Was prophylactic medication completed?
   ☐ YES ☐ NO ___ ___ ___ (Month Day Year)
2. Chest x-ray report required:
   Result: ☐ Normal ☐ Abnormal ___ ___ ___ (Month Day Year)
   "Attach chest x-ray report not film"

E. MENINGOCOCCAL VACCINE

(only vaccine for serogroups A. C. Y. W135 is acceptable)

- ☐ Menactra (MCV4) ___ ___ ___ (Month Day Year)

OR

- ☐ Menomune (MPSV4) > 5 yrs need booster ___ ___ ___ (Month Day Year)

OR

- ☐ Signed waiver form ___ ___ ___ (Month Day Year)

RECOMMENDED

A. VARICELLA VACCINE

- ☐ History of disease ___ ___ ___ (Month Day Year)

OR

- ☐ Vaccine Dose 1 ___ ___ ___ (Month Day Year)
- ☐ Vaccine Dose 2 ___ ___ ___ (Month Day Year)

OR

- ☐ Varicella antibody. Attach copy of dated immune titer.

B. Human Papilloma Virus (HPV)

Vaccine (at 0,2, and 6 month intervals)

☐ Gardasil ☐ Other

- ☐ Dose 1 ___ ___ ___ (Month Day Year)
- ☐ Dose 2 ___ ___ ___ (Month Day Year)
- ☐ Dose 3 ___ ___ ___ (Month Day Year)

HEALTH CARE PROVIDER: Name: _____ Address: _____

Date: _____ Signature: _____ Telephone: (_____) _____