Clark University Health Services
Undergraduate Immunization Record

Legal Name:_____ Date of Birth:_____ Year Entered: _____
(Last) (First) (MM/DD/YYYY)
Preferred Name: _____

Sex at birth: _____ Gender: _____ Pronouns: _____/_____/_____

Cell Phone: _____Clark Email:_____ Clark ID #: _____

Address: _____Home Country: _____

REQUIRED VACCINES	DATES GIVEN
Measles, Mumps, Rubella 2 doses MMR Dose 1 12 months of age or after, Dose 2 at least 28 days after Dose 1 **OR** MMR immune serology (titer) accepted (***attach lab documentation)***	**MMR** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** Lab documentation attached ____/____/_____ Result: _____
Hepatitis B Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 wks apart: at least 16 weeks between doses 1 and 3 **OR** Heplisav two dose series one month apart **OR** Hepatitis immune serology (titer) accepted ***(attach lab documentation)***	**HEP B** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/____ Dose 3 ____/____/_____ **OR** Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** Lab documentation attached ____/____/_____ Result: _____
Meningococcal Vaccine (ACWY) Required ≤21 years of age One dose ≥age 16 **OR** May choose to waive the vaccine. Must read, sign, and attach waiver.	☐ **Meningococcal Vaccine** MM/DD/YYYY Dose 1 ____/____/_____ **OR** Waiver attached ____/____/_____
Tetanus-Diphtheria and Pertussis 1 dose within the past 10 years Td or Tdap must be given if >10 years since Tdap	**Tdap** MM/DD/YYYY ____/____/_____ **Td** MM/DD/YYYY ____/____/_____
Varicella vaccine (Chicken Pox) 2 doses of Varicella at least 4 wks apart after 12 months of age **OR** History of disease **OR** Varicella immune serology (titer) accepted ***(attach lab documentation)***	**Varicella** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** History of disease ____/____/_____ Lab documentation attached ____/____/_____ Result: _____
Covid Vaccine Name: _____ **(Required by University)** US or WHO approved vaccine is acceptable	**Covid** Dose 1 ____/____/_____ Dose 2 ____/____/_____ Booster Name _____ Date ____/____/_____ *Booster dose at least 5 months after dose #2* ☐ Medical Exemption ☐ Religious Exemption
Tuberculosis Screening Form Required - Please attach	**Tuberculosis Screening form completed** Date: ____/__/___
OTHER RECOMMENDED VACCINES	**DATES GIVEN**
Human Papillomavirus (HPV) 3 doses of HPV if initiated at age 15 years or older (0, 1-2, 6 months) **OR** 2 doses if initiated before age 15 years. Dose 2 6-12 months after 1st dose	**HPV** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ Dose 3 ____/____/_____
Hepatitis A 2 doses 6 months apart age 12 months and older	**Hep A** Dose 1 ____/____/_____ Dose 2 ____/____/_____
Meningitis B (Check vaccine and dose schedule below) ☐ **Trumenba** ☐ 2 or ☐ 3 dose schedule ☐ **Bexsero** 2 doses at least 1 month apart	Dose 1 ____/____/_____ Dose 1 ____/____/_____ Dose 3 ____/____/_____
Pneumococcal (If high risk medical condition)	**Pneumococcal** Name: _____/____/_____
Influenza	**Influenza** ____/____/_____

Healthcare Provider: _____
Please print Last First NP, PA, MD, DO

Address: _____

Phone #: _____ Fax #: _____

Signature of Healthcare Provider: _____ Date: _____