

Clark University Health Services Graduate Immunization Record

Name: _____ Date of Birth: _____ Year Entered: _____
 (Last) (First)
 Cell Phone: _____ Email: _____ Department: _____ Clark ID #: _____
 Address: _____ Home County: _____ Gender: Male Female Trans _____

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 (<i>attach lab documentation</i>)	MMR MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ OR Lab documentation attached ____/____/____
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 2 doses of Merck 10 mcg Recombivax (age 11-15) OR Hepatitis immune serology (titer) accepted (<i>attach lab documentation</i>)	HEP B MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ Dose 3 ____/____/____ OR Dose 1 ____/____/____ Dose 2 ____/____/____ OR Lab documentation attached ____/____/____
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.	<input type="checkbox"/> Meningococcal Vaccine MM/DD/YYYY Dose 1 ____/____/____ OR Waiver attached ____/____/____
Tetanus-Diphtheria and Pertussis 1 dose within the past 10 years	Tdap 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 (<i>attach lab documentation</i>)	Varicella MM/DD/YYYY Dose 1 ____/____/____ Dose 2 ____/____/____ OR History of disease ____/____/____ Lab documentation attached ____/____/____
Tuberculosis Screening Complete Massachusetts DPH Tuberculosis Risk Assessment and submit with your health forms. If risk factor(s) present complete Interferon Gamma Release Assay (IGRA) or Tuberculin Skin Test (TST) below. IGRA MM/DD/YYYY Date obtained: ____/____/____ Specify method: <input type="checkbox"/> QFT-GIT <input type="checkbox"/> T-spot Result : <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate <input type="checkbox"/> Borderline (T-spot only) (<i>attach lab documentation</i>)	TST MM/DD/YYYY Date given: ____/____/____ Date read: ____/____/____ Result ____ mm of induration (transverse diameter only) Chest x-ray required if TST or IGRA is positive Date of chest x-ray: ____/____/____ Result <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Prophylactic medications Medication Names: _____ Date started: ____/____/____ Date ended: ____/____/____
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 1 st 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) <input type="checkbox"/> Trumenba <input type="checkbox"/> 2 or <input type="checkbox"/> 3 dose schedule <input type="checkbox"/> Bexsero 2 doses at least 1 month apart	Dose 1 ____/____/____ Dose 1 ____/____/____ Dose 3 ____/____/____
Influenza (Annually) Pneumococcal (If high risk medical condition)	Influenza ____/____/____ Pneumococcal Name: ____/____/____

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

Address: _____

Phone #: _____ Fax #: _____

Signature of Healthcare Provider: _____ Date: _____