Clark University Health Services
Undergraduate Immunization Record

Name:_____ Date of Birth: _____ Year Entered: _____
(Last) (First) (MM/DD/YYYY)
Cell Phone: _____Clark Email:_____Year Entered: _____ 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 (***attach lab documentation)***	**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 ***(attach lab documentation)***	**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.	☐ **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 ***(attach lab documentation)***	**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: ☐ QFT-GIT ☐ T-sopt Result : ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-spot only) ***(attach lab documentation)***	**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 ☐ Normal ☐ 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 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 ____/____/_____
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:_____

March 2020