

Clark University Health Services Graduate 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: _____ Department: _____ 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 (<i>attach lab documentation</i>)	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 (<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 ____/____/____ 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.	<input type="checkbox"/> 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 (<i>attach lab documentation</i>)	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 ____/____/____ <i>Booster dose at least 5 months after dose #2</i> <input type="checkbox"/> <u>Medical Exemption</u> <input type="checkbox"/> <u>Religious Exemption</u>
<u>Tuberculosis Screening Form Required - Please attach</u>	<u>Tuberculosis Screening form completed</u> 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 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 ____/____/____
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: _____