Clark University Health Services
Graduate Immunization Record

Legal Name (Last, First):_____ Preferred Name:_____

Date of Birth: _____(MM/DD/YYYY) Sex assigned at birth: _____ Gender: _____ Year Entered:_____

Pronouns: _____/_____/_____ Cell Phone: _____ Clark ID #: _____ Home Country: _____

Clark Email:_____ Address: _____

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 weeks apart: at least 16 weeks between doses 1 and 3 OR Heplisav two dose series one month apart ≥ 18 years old 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 years old OR May choose to waive the vaccine. Must read, sign, and attach waiver	**Meningococcal Vaccine** 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 weeks 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: _____
Tuberculosis Screening Form Required - Please attach	**Tuberculosis Screening form completed Date: ____/____/____**
OTHER RECOMMENDED VACCINES	**DATES GIVEN**
Covid Vaccine: (Please specify manufacture: Pfizer-BioNTech, Moderna, or Novavax recommended) 1 dose of an updated Covid booster	**Covid** Booster Name _____ Date___/____/____
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 2 ____/____/_____ Dose 3 ____/____/_____
Pneumococcal (If high risk medical condition)	Pneumococcal Name:_____ Date:____/____/_____
Influenza	Influenza Date:____/____/_____

Healthcare Provider: _____NP, PA, MD, DO (Please print)

Address:_____Phone#:_____

Fax #:_____ Signature of Healthcare Provider:_____Date:_____