Clark University Health Services
Undergraduate 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:__________

March 2024