

**WHEELING JESUIT UNIVERSITY
STUDENT HEALTH CENTER
IMMUNIZATION RECORD**

STUDENT NAME: _____

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER. MEDICAL OR RELIGIOUS EXEMPTIONS TO THE REQUIREMENTS MUST BE VERIFIED WITH A LETTER ON OFFICIAL STATIONERY AND SIGNED BY A PHYSICIAN OR CHURCH OFFICIAL. WHEELING JESUIT UNIVERSITY REQUIRES THAT ALL NEW STUDENTS SHOW PROOF OF IMMUNIZATIONS. STUDENTS WILL NOT BE PERMITTED TO REGISTER FOR CLASSES WITHOUT COMPLETION OF THIS FORM.

A. M.M.R. (MEASLES, MUMPS, RUBELLA) (MANDATORY) **Month/Day/Year**
(2 doses if you were born after December 31, 1956)
1. DOSE 1 - IMMUNIZED AT 12 MONTHS OR AFTER AND BEFORE 5 YEARS _____
2. DOSE 2 - IMMUNIZED AT 5 YEARS OR LATER _____

*** OR ***

MEASLES (RUBEOLA) - IF GIVEN INSTEAD OF M.M.R.
(2 doses required if you were born after December 31, 1956)
1. IMMUNIZED WITH LIVE MEASLES VACCINE AT 12 MONTHS AFTER BIRTH AND SECOND DOSE LATER _____
2. HAD DISEASE; CONFIRMED BY OFFICE RECORD _____
3. HAS REPORT OF IMMUNE TITER; SPECIFY DATE _____

RUBELLA - IF GIVEN INSTEAD OF M.M.R.
(1 dose required if you were born after December 31, 1956)
1. IMMUNIZED WITH VACCINE AT 12 MONTHS OF AGE OR LATER _____
2. HAD DISEASE; CONFIRMED BY OFFICE RECORD OR TITER _____

MUMPS - IF GIVEN INSTEAD OF M.M.R.
1. IMMUNIZED WITH VACCINE AT 12 MONTHS OF AGE BIRTH OR LATER _____
2. HAD DISEASE; CONFIRMED BY OFFICE RECORD OR TITER _____

B. TETANUS - DIPHTHERIA (MANDATORY)
1. COMPLETED PRIMARY SERIES OF TETANUS-DIPHTHERIA IMMUNIZATIONS _____
2. RECEIVED TETANUS-DIPHTHERIA BOOSTER WITHIN LAST 10 YEARS _____

C. TUBERCULOSIS SCREENING (MANDATORY)
1. PPD [MANTOUX] TEST WITHIN THE PAST YEAR (TINE OR MONOVAC NOT ACCEPTABLE)
RESULT: _____ POSITIVE _____ mm/INDURATION _____ NEGATIVE _____
2. POSITIVE PPD - CHEST X-RAY REQUIRED (GIVE DATE AND RESULT OF X-RAY)
RESULT: _____ POSITIVE _____ NEGATIVE _____

D. POLIO (MANDATORY)
1. HAD PRIMARY SERIES IN CHILDHOOD _____

E. HEPATITIS B VACCINES (Series of 3) (MANDATORY)
1. _____ 2. _____ 3. _____

F. BACTERIAL MENINGITIS VACCINE (MENOMUNE) (MANDATORY) _____

G. VARIVAX VACCINES (HIGHLY RECOMMENDED IF NO IMMUNITY TO CHICKENPOX)
1. _____ 2. _____ or have you had chicken pox? Date _____

Name of Public Health Clinic or Physician (Office Stamp)

Physician or Authorized Signature

Date