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 IMMUNIZATION __________________
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 __________________
3. (GIVE DATE AND RESULT OF X-RAY) __________________
RESULT: _______ POSITIVE _______ NEGATIVE __________________

D. POLIO (MANDATORY) PRIMARY SERIES IN CHILDHOOD __________________

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

F. BACTERIAL MENINGITIS VACCINE (MANDATORY FOR ALL STUDENTS) __________________

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

Rev. 02/06/2006

PLEASE KEEP A COPY FOR YOUR RECORDS