

**IMMUNIZATION HISTORY RECORD**

**PLEASE READ THIS FORM CAREFULLY BEFORE FILLING IT OUT**

**GUIDELINES FOR COMPLETION:**

**Please complete this section in its entirety AND attach copy of official immunization records. Your HOUSING ASSIGNMENT will be on HOLD until we receive this form AND a copy of your official immunization records.**

Last Name	First Name	Middle Name	Date of Birth (mo/day/yr)
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**SECTION A: REQUIRED IMMUNIZATIONS**

**Polio:** (Series of four)

Date of dose #1: \_\_\_/\_\_\_/\_\_\_    Date of dose #2: \_\_\_/\_\_\_/\_\_\_    Date of dose #3: \_\_\_/\_\_\_/\_\_\_    Date of dose #4: \_\_\_/\_\_\_/\_\_\_

**Tetanus/Diphtheria:** Three doses of Diphtheria/Tetanus/Pertussis (DPT or DTaP or DT) in childhood and a booster of Tetanus/Diphtheria (**Td**) or **Tdap** within the last tens years.

Date of dose #1: \_\_\_/\_\_\_/\_\_\_    Date of dose #2: \_\_\_/\_\_\_/\_\_\_    Date of dose #3: \_\_\_/\_\_\_/\_\_\_  
**Date of booster:** \_\_\_/\_\_\_/\_\_\_ **must be within the last 10 years or recent Tdap**    **Tdap:** date of dose: \_\_\_/\_\_\_/\_\_\_

**Tuberculosis Screening:** A MANTOUX (PPD) skin test **is required within the year**. If the skin test is positive or student has a history of a positive skin test, then a **copy of chest x-ray report within the last six months is required**.

Date of skin test: \_\_\_/\_\_\_/\_\_\_    Date test read: \_\_\_/\_\_\_/\_\_\_    Reading \_\_\_\_\_ mm    Read by: \_\_\_\_\_  
(Initial)

Patient received INH: \_\_\_NO \_\_\_YES    Duration of treatment: \_\_\_\_\_ months    Date treatment completed: \_\_\_\_\_

**Measles/ Mumps/ Rubella (MMR Series):** Two doses are required if born after 1957

Date of dose #1: \_\_\_/\_\_\_/\_\_\_    Date of dose #2: \_\_\_/\_\_\_/\_\_\_

**Hepatitis B Series:** (Series of three)

Date of dose #1: \_\_\_/\_\_\_/\_\_\_    Date of dose #2: \_\_\_/\_\_\_/\_\_\_    Date of dose #3: \_\_\_/\_\_\_/\_\_\_

**Varicella (Chicken Pox) Series:** (Must submit either two dates of immunizations or date of disease.)

**Varicella vaccine:**    Date of dose #1: \_\_\_/\_\_\_/\_\_\_    Date of dose #2: \_\_\_/\_\_\_/\_\_\_

**OR** Date of disease: \_\_\_/\_\_\_  
 Mo Yr

**SECTION B: RECOMMENDED IMMUNIZATIONS**

**Meningococcal:** Date of dose: \_\_\_/\_\_\_/\_\_\_

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**Print Name of Health Care Provider or Clinician    Office/Clinic Name    Office/Clinic Address    Office/Clinic Phone Number**  
 Mail or fax all information to Spring Arbor University Holton Health Center **Fax:** (517) 750-6625