SPRING ARBOR
UNIVERSITY

Holton Health & Wellness Center
106 E. Main St.
Spring Arbor, MI 49283
(517) 750-6352

# 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, including proof of a NEGATIVE TB Test within the past year. HOUSING ASSIGNMENT will be on HOLD until we receive this form AND COPY OF YOUR OFFICIAL IMMUNIZATION RECORDS, INCLUDING TB RESULT.**

Last Name First Name Middle Name Date of Birth (mo/day/yr)

## SECTION A: REQUIRED IMMUNIZATIONS

**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.**

*****MANDATORY-CANNOT BE WAIVED*****

**Date of skin test: ___/___/___ Date test read: ___/___/___ Reading ________mm Reading Professional:___________________**
**(Signature)**

**Patient received INH: ___NO ___YES Duration of treatment: ________months Date treatment completed: _____________**

**POLIO:** (Series of four)

Date of dose #1: ___/___/___ Date of dose #2: ___/___/___ Date of dose#3: ___/___/___ Date of dose #4: ___/___/___

**TETANUS/DIPTHERIA:** **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 ten 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: ___/___/___

**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: ___/___/___

_______________________________________________________________________________(___)___________________
**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 and Wellness Center **Fax:** (517) 750-6625 HH&WC 2/13