IMMUNIZATION VERIFICATION FORM

Immunization History (Student Name: ______________________)

Last First

Please fill in dates given (Month, Date, and Year) (xx-xx-xxxx)

Polio: Date original series completed or reimmunized:
(REQUIRED for all Nursing students)

T d + Pertussis

Tetanus: Last booster (Must be within 10 years)

MMR (Measles, Mumps, Rubella) 1st Dose __________ 2nd Dose __________
(Two doses required before 1st birthday)

OR MMR Titers (Must attach lab results)

Measles __________ Mumps __________ Rubella __________

Hepatitis B: (series of 3 injections)

1st Dose __________ 2nd Dose __________ 3rd Dose __________

Or HBsAB (titer) (Must attach lab results)

Varicella (Chicken Pox) must have vaccines or titer

Varicella Vaccine 1st Dose __________ 2nd Dose __________

Or Varicella Titer (Must attach lab results)

If student had Chicken Pox, student must have Varicella titer.

(Must attach lab results to show immunity) If history of disease, MUST have immune titer

Primary Care Provider Name/Credentials: ____________________________ (PRINT)

Primary Care Provider Signature: ____________________________

Primary Care Provider Address: ____________________________

Telephone: ____________________________