Clark University Health Services
Undergraduate Immunization Record

Name:_____ Date of Birth: _____ Clark ID #: _____
(Last) (First) (MM/DD/YYYY)
Cell Phone: _____Clark Email:_____Year Entered: _____ Gender: ☐ Male ☐ Female ☐ Trans _____

REQUIRED VACCINES	DATES GIVEN
Measles, Mumps, Rubella 2 doses MMR Dose 1 12 months of age or after, Dose 2 at least 28 days after Dose 1 **OR** MMR immune serology (titer) accepted (attach lab documentation)	**MMR** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** Lab documentation attached ____/____/_____
Hepatitis B Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 wks apart: at least 16 weeks between doses 1 and 3 **OR** 2 doses of Merck 10 mcg Recombivax (age 11-15) **OR** Hepatitis immune serology (titer) accepted (attach lab documentation)	**HEP B** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ Dose 3 ____/____/_____ **OR** Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** Lab documentation attached ____/____/_____
Meningococcal Vaccine (ACWY) Required ≤21 years of age One dose ≥age 16 **OR** May choose to waive the vaccine. Must read, sign, and attach waiver.	☐ **Meningococcal Vaccine** MM/DD/YYYY Dose 1 ____/____/_____ **OR** Waiver attached ____/____/_____
Tetanus-Diphtheria and Pertussis 1 dose within the past 10 years	**Tdap** MM/DD/YYYY ____/____/_____
Varicella vaccine (Chicken Pox) 2 doses of Varicella at least 4 wks apart after 12 months of age **OR** History of disease **OR** Varicella immune serology (titer) accepted (attach lab documentation)	**Varicella** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ **OR** History of disease ____/____/_____ Lab documentation attached ____/____/_____
Tuberculosis Screening Complete TB risk questionnaire Part I ☐ High risk ☐ Low risk (yes to any question(s) on questionnaire is high risk) If **high risk** complete Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) below: **TST** MM/DD/YYYY Date given: ____/____/_____ Date read: ____/____/_____ Result _____ mm of induration (transverse diameter only) **OR**	**IGRA** MM/DD/YYYY Date obtained: ____/____/_____ Specify method: ☐ QFT-GIT ☐ T-sopt Result : ☐ Negative ☐ Positive ☐ Indeterminate ☐ Borderline (T-spot only) **Chest x-ray required if TST or IGRA is positive** Date of chest x-ray: ____/____/_____ Result ☐ Normal ☐ Abnormal **Prophylactic medications** Medication Names: _____ Date started: ____/____/_____ Date ended: ____/____/_____
OTHER RECOMMENDED VACCINES	**DATES GIVEN**
Human Papillomavirus (HPV) 3 doses of HPV if initiated at age 15 years or older (0, 1-2, 6 months) **OR** 2 doses if initiated before age 15 years. Dose 2 6-12 months after 1st dose	**HPV** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ Dose 3 ____/____/_____
Hepatitis A 2 doses 6 months apart age 12 months and older	**Hep A** Dose 1 ____/____/_____ Dose 2 ____/____/_____
Meningitis B (Check vaccine and dose schedule below) ☐ **Trumenba** ☐ 2 or ☐ 3 dose schedule ☐ **Bexsero** 2 doses at least 1 month apart	Dose 1 ____/____/_____ Dose 1 ____/____/_____ Dose 3 ____/____/_____
Influenza (Annually) **Pneumococcal** (If high risk medical condition)	**Influenza** ____/____/_____ **Pneumococcal** Name:_____ ____/____/_____

Healthcare Provider: _____
Please print Last First NP, PA, MD, DO

Address:_____

Phone #:_____ Fax #:_____

Signature of Healthcare Provider:_____ Date:_____

March 2018