IMMUNIZATION RECORD
Graham Health Center at Oakland University

SUBMIT TO GHC ON MOVE- IN DAY OR SEND A COPY OF THIS FORM VIA:

MAIL:	EMAIL:	FAX:
Oakland University Graham Health Center 2200 N. Squirrel Rd. Rochester, MI 48309-4401	health@oakland.edu	248-370-2691

Name _____
Last first middle

Today's date ____/____ /___ Date of Birth ___/___/___ G # _____
M D Y M D Y

MMR (MEASLES, MUMPS, RUBELLA) VACCINE

Dose #1 ___/___/___
M D Y

Dose# 2 ___/___/___
M D Y

VARICELLA VACCINE

History of Disease Yes _____ No _____

Dose #1 ___/___/___
M D Y

Dose #2 ___/___/___
M D Y

TETANUS-DIPHTHERIA-PERTUSSIS VACCINE

Last Booster: Td or Tdap (please circle) ___/___/___
M D Y

HUMAN PAPILLOMAVIRUS VACCINE (HPV – Gardasil or Cervirax)

Dose #1 ___/___/___ Dose #2 ___/___/____ Dose #3 ___/___/___
M D Y M D Y M D Y

HEPATITIS B VACCINE

Dose #1 ___/___/__ Dose #2 ___/___/___ Dose #3 ___/___/___
M D Y M D Y M D Y

MENINGOCOCCAL VACCINE

Dose #1 ___/___/___ Dose #2 ___/___/___ (needed if received first dose before age 16)
M D Y M D Y