GEORGETOWN COLLEGE
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The Student Wellness Center Health Services

Immunization Record

PART I - Student Information

Name: _____ Date of Birth: _____
(Last) (First) (Middle)

SSN#: _____ Male ___ Female ___ Date form completed: _____

Permanent Address: _____
(Street) (Apt.) (City) (State/Province) (Zip/Postal Code) (Country)

PART II - To be completed and signed by your Health Care Provider. ***All information must be in English***

A. Tetanus - Diphtheria
Tetanus-Diphtheria booster must be within the last ten years..... _____/_____ Mo Yr

B. M.M.R. (Measles, Mumps, Rubella) (two doses required or individual vaccine as noted below)
Dose 1 given at 12 months after birth or later and Dose 2 after 1980..... 1. ____/_____ 2._____/_____ Mo Yr Mo Yr

C. Measeles (Rubeola) (Check all that Apply)
1. Immunized with live measles vaccine at 12 months after birth or later & after 1980..... 1. ____/_____ 2._____/_____ Mo Yr Mo Yr
2. Has report of positive immune titer. Specify Date..... _____/_____ Mo Yr
3. Had disease confirmed by doctor's records. ..... _____/_____ Mo Yr

D. Rubella - German Measles (clinical history is not acceptable) (check all that apply)
1. Immunized with live measles vaccine at 12 months after birth or later & after 1980..... 1. ____/_____ 2._____/_____ Mo Yr Mo Yr
2. Has report of positive immune titer. Specify Date..... _____/_____ Mo Yr

E. Mumps (Check all that apply)
1. Immunized with live measles vaccine at 12 months after birth or later & after 1980..... 1.____/_____ 2._____/_____ Mo Yr Mo Yr
2. Has report of positive immune titer. Specify Date..... _____/_____ Mo Yr
3. Had disease confirmed by doctor's records. ..... _____/_____ Mo Yr

F. Tuberculosis *(PPD required regardless of prior BCG inoculation)*
1. PPD (Mantoux) within the past 12 months (tine or momovac not acceptable)
Result: Neg ____ Pos ____ mm induration (horizontal diameter) ____ ..... _____/_____ Mo Yr
2. If greater than 5mm induration, chest X-ray required. X-ray result: Normal ____ Abnormal ____
3. Received BCG: Yes ____ No ____ If yes: ..... _____/_____ Mo Yr
4. PPD prior to last 12 months: Yes ____ No ____ mm induration (horizontal diameter) ____

G. Polio
1.Completed primary series of polio immunization: Yes ____ No ____ Date of last booster: ..... _____/_____ Mo Yr
2. Type of vaccine: Live (OPV) ____ Inactivated (IPV) ___ Enhanced Potency (EP-IPV) ___

H. Hepatitis B (strongly recommended)..... 1. Completion of at least two of three required doses: 1 _____/_____ 2. _____/_____ 3. _____/_____ Mo Yr Mo Yr Mo Yr
2. Hepatitis B surface antigen antibody..... _____/____ Reactive ____ Non-Reactive ____ Mo Yr

I. Meningitis (recommended) ..... Vaccinated _____/_____ Mo Yr

J. Varicella.....Hx of Disease Yes ____ No ____ .....Vaccinated _____/_____ _____/_____ Mo Yr Mo Yr

Health Care Provider (Name and Address):_____

Signature and date: _____ **Phone:** _____