UW-Stout Student Health Services
Menomonie, Wisconsin 54751

UNIVERSITY OF WISCONSIN STOUT

Immunization Record and Recommendations

Please read the following information carefully and fill out every field. If you have any questions, please call 715/232-1314.

Name:____

Student ID # ______________________________ **DOB:**______________________

❑ Check here if you are a "distance learner", for exemption. **(You do not need to complete this form)**.

M.M.R (Measles, Mumps, Rubella) (Two doses required.)

Dose #1 __/__/__

Dose #2 __/__/__

❑ Check here if you were born before January 1, 1957, for age exemption.

TETANUS-DIPHTHERIA (Primary series with DTaP or DTP and booster dose of TdaP or Td in the last 10 years meets requirement.)

Doses #1 __/__/__ #2 __/__/__ #3 __/__/__

#4 __/__/__ #5 __/__/__

Tdap (Boostrix or Adacel) or **TD** booster dose every 10 years
Date of last Booster__/__/__

POLIO (Primary series in childhood meets requirement.)

Doses: #1 __/__/__ #2 __/__/__ #3 __/__/__ #4 __/__/__

VARICELLA (Chicken Pox) (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine)

History of Disease Yes _____ No _____

OR

Varicella antibody __/__/__ Reactive ______ Non-reactive ______

OR

Immunization Dose #1 __/__/__ Dose #2 __/__/__

HEPATITIS B (Three doses of vaccine required)

Dose #1 __/__/__

Dose #2 __/__/__

Dose #3 __/__/__

HEPATITIS A (Two doses of vaccine 6 month apart)

Dose #1 __/__/__

Dose #2 __/__/__

MENINGOCOCCAL (Meningitis) VACCINE

Date __/__/__

(One dose at entry into college for freshmen living in residence halls and anyone who wishes to reduce their risk of meningitis.)

HPV VACCINE (Human papilloma virus)

Dose #1 __/__/__

Dose #2 __/__/__

Dose #3 __/__/__

By signing below …. *I certify that the above information is true and accurate of the dates on which immunizations were received.*

Signature of student, or parent: ______________________________ Date: ______________

Medical Exemption

Medical Exemption: the student named above does not have one or more of the immunizations because they have:
(check all that may apply and fill in the blanks)

- ❑ shown laboratory evidence of immunity against ____________________ disease(s)
- ❑ a medical problem that precludes the ____________________ vaccine(s)
- ❑ had disease ____________________
- ❑ not been immunized because of a history of ____________________ disease

Signature ______________________________ Date ______________

Conscientious Exemption

Conscientious Exemption: I hereby certify by my signature that immunization against ______________ is contrary to my conscientiously held beliefs.

Signature ______________________________ Date ______________

Please return forms:
Immunization Record · Minor's consent Form (if applicable)
to: Student Health Services prior to first day of classes.

Mail to: UW-Stout Student Health Services
103 1st Ave W., Menomonie, WI 54751
Make a copy to keep with your personal records.