

## 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 he/she has:  
(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 \_\_\_\_\_