ACADEMIC YEAR ______/______

Immunization Record Form

PART I - To be completed by student

Name ______________________ (Last) ______________________ (First) ______________________ (Middle) Date of Birth ______/______/______ (Month / Day / Year)

Permanent Address ____

City ______________________ State __________ Zip/Postal Code ____________ Country ______________

Home Phone (__________)______________________ Student's Cell Phone (__________)______________________

Will you be using this cell phone at CLU? ☐ Yes ☐ No

CLU Email ____

Date of entry at CLU ______/______ (Month / Year) Status: ☐ Commuter ☐ On campus (residential student)
☐ Freshman ☐ Transfer ☐ Undergraduate ☐ Graduate

PLEASE MAIL COMPLETED FORM TO HEALTH SERVICES IN ENCLOSED ENVELOPE BY AUGUST 1ST

PART II – To be completed and signed by your health care provider. All information must be in English.

A. REQUIRED IMMUNIZATIONS – Student registration will be held if not completed.
Please list dates as: Month/Day/Year

1. MMR - Measles, Mumps and Rubella

(Two doses of MMR or positive antibody for Rubeola, Mumps and Rubella required for all students)

Dose 1 given on or after first birthday #1 ______/______/______

Dose 2 given at least 28 days after first dose and after 1989 #2 ______/______/______

(OR can perform lab testing below)

Rubeola antibody (IgG) titer result ☐ Immune ☐ Non-Immune Date ______/______/______

Rubella antibody (IgG) titer result ☐ Immune ☐ Non-Immune Date ______/______/______

Mumps antibody (IgG) titer result ☐ Immune ☐ Non-Immune Date ______/______/______

2. Tetanus* (Primary series with DTaP or DTP and booster with Td or Tdap in the last ten years meets requirement. Refer to ACIP for details.)

Tetanus-Diphtheria (Td) or Tetanus, Diptheria, Pertussis (Tdap) booster *within the last 10 yrs* ______/______/______

(AND)

Did patient finish primary series of DTaP or DTP? ☐ Yes ☐ No

3. Hepatitis B* (Three doses of vaccine or a positive Hepatitis B surface antibody meets requirement. If student has not completed series or is not immune, the first dose is required prior to matriculation and subsequent doses can be given at Student Health Services).

Dose #1 ______/______/______ Dose #2 ______/______/______ Dose #3 ______/______/______

(OR can perform lab testing below)

Positive Hepatitis B surface antibody (IgG) Date ______/______/______ Result: ☐ Immune ☐ Non-Immune

**Hepatitis B and Td are required for residential students, athletes and cheerleaders. They are strongly recommended for all students. Commuter students only need to fulfill MMR requirement (1.)*

HEALTH SERVICES
60 WEST OLSEN ROAD, #4300
THOUSAND OAKS, CA
91360-2700
T: (805) 493-3225
F: (805) 493-3955

WWW.CALLUTHERAN.EDU/HEALTH

CONTINUED ON BACK

B. RECOMMENDED IMMUNIZATIONS (Recommended for all freshman by the American College Health Foundation, but student registration will not be held if not documented)

1. **Meningococcal – Strongly Recommended** (One dose, preferably at entry into college for freshmen living in residence halls. Any undergraduate less than 25 years who wishes to reduce their risk of disease can consider the vaccine. Students with immunodeficiency such as complement deficiency/asplenia should receive vaccine every 3-5 yrs.)

   ☐ Menactra Date ______/______/______ **(OR)** ☐ Menomune Date ______/______/______

2. **Varicella** (Either a history of chicken pox, a positive varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years meets requirement.)

   History of disease ☐ Yes ☐ No

   (OR)

   Varicella antibody ______/______/______ ☐ Reactive ☐ Nonreactive

   (OR)

   Immunization

   Dose #1 ______/______/______

   Dose #2, given at least one month after first dose, if age 13 or older ______/______/______

3. **Hepatitis A**

   Dose #1 ______/______/______

   Dose #2 ______/______/______

4. **Human Papillomavirus**

   Dose #1 ______/______/______

   Dose #2 ______/______/______

   Dose #3 ______/______/______

MUST BE SIGNED BY HEALTH PROFESSIONAL OR PROVIDE COPY OF IMMUNIZATION RECORD THAT HAS ALL REQUIRED IMMUNIZATIONS LISTED

Health Professional Signature ______________________________ Date ______/______/______

Name (Please Print) ______________________________

Street Address ______________________________ Telephone (______)______________

City ______________________ State ____________ Zip Code ____________

REFERENCES FOR HEALTH CARE PROVIDERS:

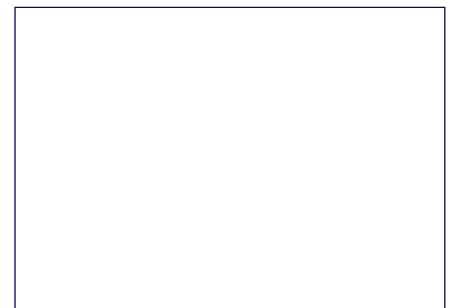
Advisory Committee on Immunization Practices (ACIP) recommendations.

American College Health Association

"Recommendations for Institutional Prematriculation Immunizations," August 2006. *www.acha.org*

PLEASE MAIL THIS COMPLETED FORM IN THE ENCLOSED ENVELOPE TO:

California Lutheran University
Health Services
60 West Olsen Rd. #4300
Thousand Oaks, CA 91360-2700



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