

Complete the following:

Last (Family) Name _____ First Name _____ Middle Initial _____
 Birth Date _____ SMC ID# _____
 Program: ☐ Undergraduate ☐ English Language/Pathway ☐ Other
 UNDERGRADUATES ONLY: Class Year _____

Immunization Record

DEADLINE

Fall semester undergraduate students - due by **JUNE 15**

All other programs – due no later than **one month** before classes start

**RETURN BY
MAIL, EMAIL
OR FAX**

Student Health Services, Saint Michael's College, One Winooski Park, Box 259, Colchester, VT 05439
 Email: mmasson@smcvt.edu • Fax: +1.802.654.2699 • Phone: +1.802.654.2234

Vermont state law requires that all students have the following immunizations.

THIS PORTION OF THE FORM SHOULD BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (DOCTOR/NURSE).

Vaccine Against	Dates Given	Vermont Dept. of Health Requirements
Tdap or Td <i>Tetanus-Diphtheria-Pertussis</i>	Tdap <input type="checkbox"/> Td <input type="checkbox"/> _____ mm / dd / yy	1 Tdap/Td booster within last 10 years (Tdap preferred)
MMR <i>Measles-Mumps-Rubella</i>	#1 _____ #2 _____ OR Positive Titer* Dates: _____ Measles _____ Mumps _____ Rubella	2 doses or positive titer Minimum of 4 weeks between doses.
Bacterial Meningitis	_____	1 dose given within last 5 years for students living in campus-based housing.
Varicella <i>(Chicken Pox)</i>	1. History of disease: Yes <input type="checkbox"/> No <input type="checkbox"/> (if No, proceed to 2.) 2. Immunization: #1 _____ #2 _____ OR Positive Titer* Date: _____	2 doses of varicella vaccine, or history of disease, or positive titer.
Hepatitis B	#1 _____ #2 _____ #3 _____ OR Positive Titer* Date: _____	3 doses or positive titer. Minimum of 4 weeks between doses 1 and 2. Minimum of 8 weeks between doses 2 and 3. (3 rd dose must be 16 weeks after first dose.)

*Titer: A titer is a laboratory test which documents immunity to a disease.

HEALTH CARE PROVIDER INFORMATION AND SIGNATURE:

Name: _____ Phone: _____

Address: _____

Signature: _____