LANDMARK
COLLEGE

Health Records: Immunization Record

REQUIRED FORM

PART ONE: To be filled out by student

Name: _____
LAST NAME FIRST NAME

Address: _____
STREET CITY STATE ZIP

Date of Entry _____ Date of Birth _____

PART TWO: Must be completed and signed by your Health Care Provider

(DO NOT ATTACH IMMUNIZATION RECORD)

The immunization protocol is mandated by the State of Vermont.

A. M.M.R. (Measles, Mumps, Rubella) *(REQUIRED)* (Two doses required at least 28 days apart for students born after 1956)
Dose #1 (M/D/Y) _____ Dose#2 (M/D/Y) _____ **OR**

Positive titer required Result ☐ Reactive ☐ Non-reactive

B.VARICELLA *(REQUIRED)* (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.) Both doses should be done prior to registration, as this is a state funded vaccine.

1. History of Disease Yes ☐ No ☐ or if no, proceed to #2
2. Immunization Dose #1 (M/D/Y) _____ Dose #2 (M/D/Y) _____ **OR**
3. Varicella antibody (M/D/Y) _____ Result: Reactive ☐ Non-reactive ☐

C.TETANUS-DIPTHERIA-PERTUSSIS *(REQUIRED,)* (Booster with Td or Tdap in the last ten years.)

1. Date of most recent booster dose (M/D/Y) _____
   Type of booster: Td ☐ Tdap ☐ (Tdap booster recommended for ages 11-64 unless contraindicated.)

D.HEPATITIS B *(REQUIRED)* (Three doses of vaccine or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization

Dose #1 (M/D/Y) _____ Dose #2 (M/D/Y) _____ Dose #3 (M/D/Y) _____ **OR**
Positive titer required Result Reactive ☐ Non-reactive ☐

E.MENINGOCOCCAL TETRAVALENT *(REQUIRED)*

(A, C, Y, W-135 / for all students. College students over 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.)

Dose #1 (M/D/Y) _____ Revaccinate if 1st dose was given before age 16 Dose #2 (M/D/Y) _____

HEALTH CARE PROVIDER

Name _____ M.D./N.P/P.A Address _____

Signature _____ Date _____ Phone _____