NORTHEASTERN BAPTIST COLLEGE

OFFICE OF STUDENT LIFE

Immunization Record

While the information presented on this form is confidential and will not affect your admission status, we must have the following information to legally allow you to enroll in classes or reside in student housing. If claiming an exemption for a vaccination(s) based on medical, religious, or philosophical reasoning, the Vermont State exemption form must be submitted in lieu of this Immunization Record.

Student's Name: _____ Date of Birth: ____/_____/_____

Vaccines	Dates Given	Vermont State Requirements
MMR	#1 ___/___/___ #2 ___/___/___ or Positive Titer Date: ___/___/___	
Measles	#1 ___/___/___ #2 ___/___/___ or Positive Titer Date: ___/___/___	2 doses or positive titers Minimum of 4 weeks between doses
Mumps	#1 ___/___/___ #2 ___/___/___ or Positive Titer Date: ___/___/___	First dose given after first birthday Option of combined MMR or individual vaccines
Rubella	#1 ___/___/___ #2 ___/___/___ or Positive Titer Date: ___/___/___	
Tdap or Td	Tdap _____ Td _____ Date: ___/___/___	1 Tdap/Td booster within last 10 years
Meningococcal	#1 ___/___/___ #2 ___/___/___	Only required of students under the age of 21 living in student housing Second dose is required if first dose was given under the age of 16
Varicella	#1 ___/___/___ #2 ___/___/___ or Positive Titer Date: ___/___/___ or History of Disease: Date: ___/___/___	2 doses of Varicella vaccine or positive titer or history of disease Minimum of 4 weeks between doses if age 13 or older If submitting history of disease, complete the Vermont State documentation of disease form
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ or Positive Titer Date: ___/___/___	3 doses or positive titer minimum interval between dose 1 and 2 is 4 weeks minimum interval between dose 2 and 3 is 8 weeks minimum interval between dose 1 and 3 is 16 weeks minimum age for the final dose is 24 weeks

Signature of Health Care Provider:

_____

PRINT SIGNATURE DATE

_____

ADDRESS PHONE

Documentation of Varicella (Chickenpox) Disease

VERMONT
DEPARTMENT OF HEALTH

Vermont's School Immunization Regulations apply to students in attendance at any public or independent kindergarten, any elementary or secondary school and certain post-secondary schools. Before school entry, students must have the required immunizations, including 2 doses of varicella (chickenpox) vaccine. However, students who have had chickenpox disease can still enroll provided this form be completed, signed and provided to the school. Please note that this form does not need to be signed by a physician or other health care provider. **RETURN THIS FORM TO THE STUDENT'S SCHOOL.**

This document is being submitted on behalf of the following student:

Name:

_____ _____
Last First

Date of Birth :

____/____/_____

I _____ verify that the above listed student
Parent/Guardian/Self (18 and over)

had varicella (chickenpox) disease in _____/_____.
Month Year

_____ _____/_____/_____
Signature of parent or guardian of student or student 18 and over Date

RETURN THIS FORM TO THE STUDENT'S SCHOOL

The Vermont Department of Health
Immunization Program
108 Cherry Street
Burlington, Vermont 05401

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov

Post Secondary (College) Immunization Exemption Form

VERMONT
DEPARTMENT OF HEALTH

Vermont's Immunization Regulations apply to students enrolled in certain post-secondary schools. Before entry, students must have the required immunizations unless they claim a medical, religious, or philosophic exemption. In order to claim an exemption this form must be completed and returned to the college health center.

Students who claim any exemption may be kept out of classes during the course of a disease outbreak if it is determined that such students are at high risk for getting that disease and transmitting it to other students. The length of time a student is excluded from classes may vary depending on the disease and the circumstances surrounding the outbreak.

This document is being submitted on behalf of the following student:

Name: **Date of Birth:**

_____ _____ _____/_____/_____

Last **First**

MEDICAL EXEMPTION

The following vaccine(s) are medically contraindicated:

Hepatitis B **Td/Tdap** **Varicella**

Measles **Mumps** **Rubella** **Meningococcal** (1st year dormitory residents only)

Reason for exemption(s):_____

This exemption shall continue until : ____/____/_____

_____ (_____)_____

Print Name of Physician **Telephone**

_____ ___/___/_____

Signature of Physician **Date**

Check one only: **PHILOSOPHIC EXEMPTION** **RELIGIOUS EXEMPTION**

I request that following immunization(s) be waived because they conflict with free exercise of religious or philosophic rights:

Hepatitis B **Td/Tdap** **Varicella**

Measles **Mumps** **Rubella** **Meningococcal** (1st year dormitory students only)

_____ (_____)_____ ___/__/_____

Signature of Student (or parent if under 18 yrs older) **Telephone** **Date**

Vermont Department of Health
Immunization Program

802-863-7638 or
1-800-464-4343 ext. 7638
healthvermont.gov