Clark University Health Services
Graduate Immunization Record

Legal Name (Last, First):_____ Preferred Name:_____

Date of Birth: _____(MM/DD/YYYY) Sex assigned at birth: _____ Gender: _____ Year Entered:_____

Pronouns: _____/_____/_____ Cell Phone: _____ Clark ID #: _____ Home Country: _____

Clark Email:_____ Address: _____

REQUIRED VACCINES	DATES GIVEN
Measles, Mumps, Rubella: 2 doses MMR Dose 1 12 months of age or after, Dose 2 at least 28 days after Dose 1 OR MMR immune serology (titer) accepted **(attach lab documentation)**	**MMR** MM/DD/YYYY Dose 1 ____/____/_____Dose 2 ____/____/_____ OR Lab documentation attached ____/____/_____ Result: _____
Hepatitis B: Dose 1 and 2 at least 4 weeks apart; Dose 2 and 3 at least 8 weeks apart: at least 16 weeks between doses 1 and 3 OR Heplisav two dose series one month apart ≥ 18 years old OR Hepatitis immune serology (titer) accepted **(attach lab documentation)**	**HEP B** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/____ Dose 3 ____/____/_____ OR Dose 1 ____/____/_____ Dose 2 ____/____/_____ OR Lab documentation attached ____/____/_____ Result: _____
Meningococcal Vaccine (ACWY) Required ≤ 21 years of age: One dose age ≥ 16 years old OR May choose to waive the vaccine. Must read, sign, and attach waiver	**Meningococcal Vaccine** Dose 1 ____/____/_____ OR Waiver attached ____/____/_____
Tetanus-Diphtheria and Pertussis: 1 dose within the past 10 years Td or Tdap must be given if >10 years since Tdap	**Tdap** MM/DD/YYYY ____/____/_____ **Td** MM/DD/YYYY ____/____/_____
Varicella Vaccine (Chicken Pox): 2 doses of Varicella at least 4 weeks apart after 12 months of age OR History of disease OR Varicella immune serology (titer) accepted **(attach lab documentation)**	**Varicella** MM/DD/YYYY Dose 1 ____/____/_____ Dose 2 ____/____/_____ OR History of disease ____/____/_____ Lab documentation attached ____/____/_____ Result: _____
Tuberculosis Screening	**Tuberculosis Screening completed Date: ____/____/____**

1. Have you ever been diagnosed with Tuberculosis? Yes___ No___
2. Have you ever had close contact with person(s) known or suspected to have active TB disease? Yes___No___
3. Were you born in, lived, worked, or visited for more than 1 month any of the following areas? Africa, Asia, Central America, Eastern Europe, South America? Yes___ No___ Country of Birth_____
4. Have you ever had a positive PPD, TB QuantiFERON test, or T-SPOT? Yes___ No___
5. Have you ever been a resident, volunteer, and/or employee in a correctional facility, long-term care facility, hospital or drug rehabilitation unit, or homeless shelter? Yes___ No___
6. Have you been diagnosed with HIV infection, AIDS, leukemia, lymphoma, or chronic immune disorder? Yes___ No___

If patient answered YES to any of the above questions one of the following is required: PPD or QuantiFERON-TG Gold or T-SPOT.

PPD Date administered _____/_____/_____ Result _____ mm induration

QuantiFERON-TB Gold or T-SPOT Date Administered _____/____/____ Lab Report Must be Attached with Results

A chest x-ray is required if PPD results are 10mm or more or QuantiFERON-TB Gold or T-SPOT are positive.
Date of chest x-ray: ____/____/____ Result: ☐ Normal ☐ Abnormal

Healthcare Provider: _____NP, PA, MD, DO (Please print)

Address:_____Phone#:_____

Fax #:_____ Signature of Healthcare Provider:_____Date:_____

March 2026