

Clark University Health Services Undergraduate 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 a 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 Result ____ mm induration QuantiFERON-TB Gold or T-SPOT Result Date ____/____/____ Result _____ (Attach Lab Report) 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: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal	

Healthcare Provider: _____ NP, PA, MD, DO (Please print)

Address: _____ Phone#: _____

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