

Student Name: _____
Last name First name Middle initial



Center of Health and Wellbeing
425 Pearl Street Burlington, VT 05401
802-656-3350 health@uvm.edu

Date of Birth: ____/____/____ Phone: _____
mm dd yyyy

IMMUNIZATION RECORD

All undergraduate students are required by state law to provide evidence of the following vaccines.

This form is to be completed and signed by a healthcare provider.

Student to upload completed form & enter vaccine dates on [MyWellbeing.uvm.edu](https://mywellbeing.uvm.edu)

Tetanus (Tdap or Td) 1 Tdap or Td booster within last 10 years Check one: Tdap ____ or Td ____ Date: ____/____/____ mm dd yyyy	Meningococcal Conjugate (MCV4, MenACWY, MenQuadfi, Menveo, or Menactra) 1 dose required on/after 16th birthday if student is living in campus-based housing and is under 22 years old. Date: ____/____/____ mm dd yyyy
Measles, Mumps, Rubella (MMR) 2 doses of MMR vaccine. Dose 1 must be after 1st birthday; minimum 4 weeks between doses. Date 1: ____/____/____ Date 2: ____/____/____ mm dd yyyy or Positive measles titer: ____/____/____ Positive mumps titer: ____/____/____ Positive rubella titer: ____/____/____ mm dd yyyy	Varicella (chickenpox) 2 doses of Varicella vaccine; minimum 4 weeks between doses. Date 1: ____/____/____ Date 2: ____/____/____ mm dd yyyy or Positive varicella titer: ____/____/____ or Disease history: ____/____/____ mm dd yyyy

Hepatitis B (3-dose series)

Date 1: ____/____/____ Date 2: ____/____/____ Date 3: ____/____/____

*Date 4: ____/____/____ *Date 5: ____/____/____ *enter extra doses received

or

HEPLISAV-B (2-dose series)

Date 1: ____/____/____ Date 2: ____/____/____
mm dd yyyy mm dd yyyy

or
Positive surface **antibody** titer
____/____/____
mm dd yyyy

I certify that the information provided on this form is complete, true, and correct to the best of my knowledge.

Healthcare Provider's Signature & Credentials

Printed Name

Date

Name of Practice/Official Stamp

Provider Phone