



Center for Health & Wellbeing

425 Pearl Street, Burlington, VT 05401

IMMUNIZATION RECORD

To be completed by a health care provider and sent to UVM Student Health Services:

UPLOAD at mywellbeing.uvm.edu or FAX to (802)656-9350

Student Name: _____ Date of Birth: ____/____/____
Last Name First Name Middle Initial mm dd yr

Part I. All undergraduate students are REQUIRED by state law to provide evidence of the following immunizations:

Table with 3 columns: Vaccine Name, Dates of Vaccination, and OR Dates of Positive Titers (blood test) OR Disease History. Rows include TDAP OR TD, MENINGOCOCCAL (MCV4), HEPATITIS B, MMR (Measles, Mumps, Rubella), and VARICELLA (Chicken Pox).

Part II. Immunizations in the box below are NOT REQUIRED, but if on record please include for continuity of care:

Table with 2 columns: Vaccine Name and Dates. Rows include Polio Series (OPV/IPV Initial Series/Booster), HPV Series, and Other Vaccines.

HEALTH CARE PROVIDER'S SIGNATURE (Required if form is not accompanied by an authorized immunization document):

I certify that this student has received the immunizations or has laboratory evidence of immunity as indicated on this page.

Signature and Credentials

Printed name

Date

Office phone number

Office fax number