The University of Vermont

Center for Health & Wellbeing
425 Pearl Street, Burlington, VT 05401

Student ID #: 95__ __ __ __ __ __ __

Student Cell Phone #:(_____) _____ - _____

IMMUNIZATION RECORD

To be completed by a health care provider and sent to UVM Student Health Services:
Please UPLOAD at **mywellbeing.uvm.edu**

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:

Vaccine Name	**Dates of Vaccination**	**OR Dates of Positive Titers (blood test) OR Disease History**
TDAP OR TD *1 Tdap OR Td booster in last 10 yrs	**Check one:** Tdap ____ **OR** Td ____ Date: _____/_____/_____ mm dd yr	*Not applicable*
MENINGOCOCCAL (MCV4) **Dose 2 only required *only* if 1st dose prior to 16th birthday.	**1st year in campus housing? YES**____ **NO**____ *If **YES**, vaccine required. If **NO**, NOT required.* #1: _____/_____/_____ mm dd yr ** #2: _____/_____/_____ mm dd yr	*Not applicable*
HEPATITIS B *3 doses over 6 months	#1: ____/____/____ mm dd yr #2: ____/____/____ mm dd yr #3:____/____/____ mm dd yr	Pos. Surface AntiBody Titer : Date: ____/_____/_____ mm dd yr
MMR (Measles, Mumps, Rubella) *2 doses of MMR vaccine *Dose 1 must be after 1st birthday *Minimum 4 wks between doses	#1: _____/_____/_____ mm dd yr #2: _____/_____/_____ mm dd yr	Pos. Measles Titer: _____/_____/_____ mm dd yr Pos. Mumps Titer: _____/_____/_____ mm dd yr Pos. Rubella Titer: _____/_____/_____ mm dd yr
VARICELLA (Chicken Pox) * 2 doses of Varicella vaccine * Minimum 4 wks between doses	#1: _____/_____/_____ mm dd yr #2: _____/_____/_____ mm dd yr	Disease history: _____/_____/_____ mm dd yr **OR** Pos.Titer Date: ____/_____/_____ mm dd yr

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

Polio Series OPV/IPV Initial Series/Booster	#1 _____/_____/____ #2 _____/_____/____ #3_____/_____/_____
HPV Series	#1 _____/_____/____ #2 _____/_____/____ #3_____/_____/_____
Other Vaccines	Please attach immunization record.

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