

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

Student Name:	nt Name: Date of Birth:/							
Last Name	Fii	rst 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	Check one:	Tdap OR	Td		Not applicable			
*1 Tdap OR Td booster in last 10 yrs	Date:		Tu					
MENINGOCOCCAL (MCV4)			ing? YES If NO, NOT red		Not applicable			
**Dose 2 only required <i>only</i> if 1 st dose prior to 16 th birthday.	#1:/_ mm	/ *:	* #2:/ 	/yr				
HEPATITIS B					Pos. Surface AntiBo	dy Titer:		
*3 doses over 6 months	#1:/_ mm dd	/ #2: yr mn	// #3 n dd yr	3:// mm dd yr	Date:/ mm dd	/yr		
MMR (Measles, Mumps, Rubella)	#1:/_ mm	/_ dd yr			Pos. Measles Titer:	// mm dd yr		
*2 doses of MMR vaccine *Dose 1 must be after 1st birthday	#2:/_ mm	/dd yr			Pos. Mumps Titer:	mm dd yr		
*Minimum 4 wks between doses					Pos. Rubella Titer:	// mm dd yr		
VARICELLA (Chicken Pox)	#1:/_ mm	/ dd yr			Disease history:	// mm dd yr		
* 2 doses of Varicella vaccine * Minimum 4 wks between doses	#2:/_ mm	dd yr			OR Pos.Titer Date:	//		
Part II. Immunizations in the	he box belov	w are NOT RE	QUIRED, but i	f on record pleas	se include for cont	,		
Polio Series OPV/IPV Initial Series/Booster #1//			#2/	_/#3/				
HPV Series	#	:1/	#2/	_/#3/	/			
Other Vaccines Please attach imm			immunization r	ecord.				
HEALTH CARE PROVIDER'S I certify that this student has rece								
Signature and Credentials				Printed name	D	ate		
Office phone number				Office fax number				