

**Immunization Requirements**

*Please have the following two pages filled out by a licensed medical examiner (MD/NP/PA) and attach copies of immunization reports.*

**1. Date of Last Physical:** (**MUST** be within 1 year of school admission)

 (mm/dd/yyyy)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Measles, Mumps, Rubella (MMR)**: Provide MMR immunizations (2 doses) **or** positivetiter results as proof of immunity.

MMR #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

MMR #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Measles titer: \_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result:  Positive Negative   ⁭

Rubella titer: \_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)   Result:  Positive  ⁭ Negative   ⁭

Mumps titer:  \_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)   Result:  Positive  ⁭ Negative

**3. Tetanus, Diphtheria, Pertussis (Tdap):** Provide Tdap immunizations (3 doses) **or** positive titer results as proof of immunity. Also needs proof of current booster of **Tetanus and Diphtheria** (valid for 10 years).

Tdap #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Tdap #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Tdap #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

TD booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Tetanus titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result: Positive Negative

Diphtheria titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result: Positive Negative

Pertussis titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result: Positive Negative

**4. Hepatitis B:** Provide Hepatitis B immunizations (3 doses) **or** positive titer results as proof of immunity.

Hep B #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Hep B #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Hep B #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

HBsAb titer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(mm/dd/yyyy) Result: Positive Negative

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**5. BCG Vaccine and/or Mantoux Test:** Provide date of BCG vaccination **and/or** results of most recent Mantoux test (valid for 6 months).

BCG \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Mantoux \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result: Positive \_\_\_\_\_ mm Negative \_\_\_\_\_ mm

Date of Chest X-ray \_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yy)

**6. VDRL/RPR Test:** Provide date and results of VDRL test (valid for 6 months).

VDRL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy) Result: Positive Negative

**7. Polio Vaccine:** Provide dates of Polio vaccinations (2 doses).

Polio #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

Polio #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (mm/dd/yyyy)

*Please note that copies of all original immunization records required above should should be attached to this document.*

EXAMINER SIGNATURE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(MD/NP/PA)

Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stamp: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please submit to:**

***Elizabeth S. Stephens***
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Registered Nurse*
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