SALVE REGINA UNIVERSITY

IMMUNIZATION RECORD

THIS FORM MUST BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

OR YOU CAN SUBMIT A SIGNED IMMUNIZATION RECORD FROM YOUR PRIMARY CARE PROVIDER.

STUDENTS WHO FAIL TO PROVIDE PROOF OF THE REQUIRED IMMUNIZATIONS WILL NOT BE PERMITTED TO REGISTER FOR CLASSES.

Please print: Last Name: ____ First Name: _________________________ Date of Birth: ______________________

REQUIRED

- **MEASLES, MUMPS, RUBELLA (MMR):** Two doses of MMR are required at least one month apart or positive immune titer verifying immunity.

  MMR Dose 1 ____/_____/____ Dose 2 ____/_____/____ OR Positive Titer ____/_____/____

- **HEPATITIS B:** Three doses (doses one and two given four weeks apart and the third dose should be at least four months after first dose) or positive immune titer verifying immunity.

  Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____ OR Positive Titer ____/_____/____

- **TETANUS, DIPHTHERIA, PERTUSSIS (Tdap):** Tdap ____/_____/____

* Tetanus/diphtheria/pertussis (Tdap) within the last 10 years.

- **MENINGOCOCCAL VACCINE:** (MCV4) Dose 1 ____/_____/____ Dose 2 * ____/_____/____

* Required if under 22 years old. If you were vaccinated prior to your 16th birthday, a booster dose (Dose #2) is also required.

- **VARICELLA:** Two doses of chicken pox vaccine are required at least one month apart or positive immune titer verifying immunity or medical provider's documented history of disease.

  Dose 1 ____/_____/____ Dose 2 ____/_____/____ OR Positive titer ____/_____/____ OR Disease History ____/_____/_____

RECOMMENDED

- **COVID-19: Vaccine Name: ___________________** Dose 1 ____/____/____ Dose 2 _____/____/____ (if applicable)

  COVID-19 Booster name: _________________________ Date of **most recent** booster ____/_____/____

- **SEASONAL FLU:** ____/_____/____
- **HEPATITIS A:** Dose 1 ____/_____/____ Dose 2 ____/_____/____
- **HUMAN PAPILLOMAVIRUS VACCINE (HPV):** Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____
- **MENINGOCOCCAL SEROGROUP B: *** Dose 1 ____/_____/____ Dose 2 ____/_____/____ Dose 3 ____/_____/____

  * This is not the same as Meningococcal (MCV4)

VACCINE EXEMPTION

- **MEDICAL/RELIGIOUS EXEMPTION:** ☐ Yes * Exemption Certificate Required

Health Care Provider: ____ Date: ________________

Signature and Title: ____ Office Phone: ____________________________

REVISED AUGUST 2023