IMMUNIZATION HISTORY FORM

1. Please PRINT- This form must be completed in English using MM/DD/YY format
2. Form must be signed by a provider
3. Upload in Medical Clearances tab of Patient Portal (Immunization Record- MC)

Last Name: _____ First Name: _____

PUID #: _____ DOB: _____

A. Tetanus/ Diptheria **(Must be within last 10 years)**

Td: ___ / ___ / ___ or Tdap: ___ / ___ / ___

B. MMR (Measles, Mumps, Rubella) **(Must be on or after 1st birthday)**

MMR Dose 1: ___ / ___ / ___ MMR Dose 2: ___ / ___ / ___

OR

Measles Dose 1: ___ / ___ / ___ Measles Dose 2: ___ / ___ / ___

Mumps Dose 1: ___ / ___ / ___ Mumps Dose 2: ___ / ___ / ___

Rubella Dose 1: ___ / ___ / ___ Rubella Dose 2: ___ / ___ / ___

C. Meningococcal Quadrivalent **(Must be on or after 16th birthday)**

Only required for students 23 or younger

Most Recent Dose: ___ / ___ / ___

D. Meningococcal B **(2 doses of same brand)**

Only required for students 23 or younger

Bexsero (OMV) Dose 1: ___ / ___ / ___ Bexsero (OMV) Dose 2: ___ / ___ / ___

OR

Trumenba Dose 1: ___ / ___ / ___ Trumenba Dose 2: ___ / ___ / ___

_____ _____

Provider Signature
(MD, DO, NP, RN)

Date