IMMUNIZATION RECORD	**(Please print in black ink) To be completed and signed by PHYSICIAN or CLINIC.** A complete immunization record from a physician or clinic may be attached to this form.

Last Name	First Name	Middle Name	Date of Birth (mo/day/year)	Social Security Number

Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide personal identifier for the internal records of this institution.

SECTION A: REQUIRED IMMUNIZATIONS	Mo/day/year	Mo/day/year	Mo/day/year	Mo/day/year
DTP or Td				
Tdap (if Td not received within past 10 years)				
Polio				
MMR (after first birthday) 2 doses are required				
* Measles (after first birthday)			*Disease Date NOT Accepted	***Titer Date & Result
** Mumps			**Disease Date NOT Accepted	***Titer Date & Result
** Rubella			**Disease Date NOT Accepted	***Titer Date & Result
Hepatitis B Series				***Titer Date & Result
Varicella (chicken pox) series of 2 doses or Immunity by positive blood titer			Disease Date	***Titer Date & Result
Meningococcal (2 doses required unless 1st after 16th birthday)				

SECTION B: RECOMMENDED IMMUNIZATIONS

The following immunizations are recommended for all students and may be required by certain departments. Please consult your department materials for specific requirements. Tuberculin is required for all international students in addition to the above required immunizations.

Hepatitis A/B Series					
Tuberculin (PPD) (within 12 months)	Date Read mm induration				
Chest x-ray, if positive PPD	Date Results				
Treatment, if applicable	Date				

***Attach lab report**

SECTION C: OPTIONAL IMMUNIZATIONS	Mo/day/year	Mo/day/year	Mo/day/year
Haemophilus influenzae type b (HIB)			
Quadrivalent Human Papillomavirus Vaccine (HPV)			
Pneumococcal			
Hepatitis A series only			
Other			

* Rubeola (measles) vaccine must be repeated if received even one day prior to 12 months of age. History of physician-diagnosed measles Disease is acceptable, but physician must provide a signed statement.

** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease, even from a physician, is not acceptable.

Signature of Clinic stamp REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____ _____

Print Name of Physician/Physician Assistant/Nurse Practitioner Area Code/Phone Number

_____

Office Address City State Zip Code

Please return this form to:

Greensboro College
Student Health Center
815 West Market Street
Greensboro, NC 27401
Fax: 336-217-7299