WICKER WELLNESS CENTER

STUDENT IMMUNIZATION RECORD

PROOF OF IMMUNITY IS REQUIRED PRIOR TO REGISTRATION

UPLOAD FORM TO: Student Health Portal at www.union.studenthealthportal.com

Student Name: _____ **Date of Birth:**_____/_____/_____

This form must be completed by your healthcare provider. ALL INFORMATION MUST BE IN ENGLISH.

REQUIRED IMMUNIZATIONS

Options for Proof of Measles/Mumps/Rubella:

MMR/Measles #1: _____(mm/dd/yy)
***** 1 must have been given 12 months after birth or later to be valid****

MMR/Measles #2:_____ (mm/dd/yy)

OR

Measles Titer*: _____ (mm/dd/yy)
Or
Physician diagnosed Measles: _____ (mm/dd/yy)

Rubella Titer*: _____ (mm/dd/yy)

Mumps Titer*: _____ (mm/dd/yy)

*** Attach copy of all titer reports to this form**

Meningitis vaccine #1: _____(mm/dd/yy)

Meningitis vaccine #2: _____(mm/dd/yy)

Vaccine #1 over age 12, vaccine #2 over age 16
OR
One vaccine over the age of 16

Tetanus/Diphtheria/Pertussis (Tdap) within last 10 years

TDAP: _____ (mm/dd/yy)

HIGHLY RECOMMENDED IMMUNIZATIONS

Hepatitis A #1: _____ (mm/dd/yy)

Hepatitis A #2: _____ (mm/dd/yy)

Hepatitis B #1: _____ (mm/dd/yy)

Hepatitis B #2: _____ (mm/dd/yy)

Hepatitis B #3: _____ (mm/dd/yy)

Varicella (Chicken Pox) vaccine, if never had disease:

Varicella #1: _____ (mm/dd/yy)

Varicella #2: _____ (mm/dd/yy

Varicella titer*:_____ (mm/dd/yy)

Varicella disease:_____ (mm/dd/yy)

Human Papillomavirus Vaccine (Recommended for Female and Male Students):
HPV#1:_____ (mm/dd/yy) HPV #2:_____ (mm/dd/yy) HPV #3:_____ (mm/dd/yy)

STATEMENT OF EXEMPTION TO IMMUNIZATION LAW

In the event of an outbreak, exempted persons will be subject to exclusion from school and quarantine.

☐ **RELIGIOUS EXEMPTION:** Parent/guardian of the above named person or the person himself/herself adheres to a religious belief opposed to immunizations. **Religious Exemption Form MUST also be completed by parent/guardian or emancipated student ~ Notify the Health Center.**

☐ **MEDICAL EXEMPTION:** The physical condition of the above named person is such that immunization would endanger life or health, or is medically contraindicated due to other medical conditions. **Physician sign & date below.**

HEALTH CARE PROVIDER SIGNATURE REQUIRED **Stamp Here:**

Name (please print)_____

Address_____

City_____State_____Zip Code_____

Phone( )_____ Fax( )_____

PROVIDER SIGNATURE_____**DATE**____/____/_____