

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

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

Submit Measles, Mumps, and Rubella Lab Titrers*
*Attach copy of all titer reports to this form

Menactra or Menveo (ACWY)

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

Meningitis #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

Meningococcal B:

Bexsero

OR

Trumenba

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

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

MenB#2: _____ (mm/dd/yy)

MenB#2: _____ (mm/dd/yy)

MenB#3: _____ (mm/dd/yy)

Human Papillomavirus Vaccine (HPV): Gardasil (Recommended for Female and Male Students):

HPV#1: _____ (mm/dd/yy) HPV #2: _____ (mm/dd/yy) HPV #3: _____ (mm/dd/yy)

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): if never had disease:

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

Varicella #2: _____ (mm/dd/yy)

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

Varicella disease: _____ (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 ____/____/____