UNION COLLEGE
FOUNDED 1795

WICKER WELLNESS CENTER - STUDENT IMMUNIZATION RECORD

PROOF OF IMMUNITY IS REQUIRED PRIOR TO REGISTRATION

UPLOAD FORM TO: Student Health Portal at https://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

Tetanus/Diptheria/Pertussis (Tdap) within the last 10 years _____ (mm/dd/yy)

MMR/Measles #1: _____ (mm/dd/yy) **MMR/Measles #2**:_____ (mm/dd/yy)

 # 1 must have been given 12 months after birth or later to be valid**

OR Submit Measles, Mumps, and Rubella Lab Titers* ***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*

COVID–19 VACCINATION:

Pfizer **#1** _____ **#2** _____ **(#3)** _____

Moderna **#1** _____ **#2** _____ **(#3)** _____

Janssen **#1**_____ **#2** _____

Other - Type: _____ **Date(s):** _____

HIGHLY RECOMMENDED IMMUNIZATIONS

Meningococcal B:

Bexero MenB#1: _____(mm/dd/yy) MenB#2:_____(mm/dd/yy)

Trumenba MenB#1: _____(mm/dd/yy) MenB#2:_____(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) #2: _____ (mm/dd/yy)

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

Varicella #1: _____ (mm/dd/yy) #2: _____(mm/dd/yy) Date of 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**____/____/_____