

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_



## Swarthmore College Immunization Record

*To be completed and signed by a Health Care Professional. All information must be completed in English. You must attach immunization documents printed by your health care office. Once completed, this form along with all immunization records must be uploaded to your Student Health Portal. Dates of all immunizations must be entered on the portal.*

### The following vaccines are required:

#### A. HEPATITIS B

1. Immunization (hepatitis B)

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Adult formulation \_\_\_\_\_ Child formulation \_\_\_\_\_ Adult formulation \_\_\_\_\_ Child formulation \_\_\_\_\_ Adult formulation \_\_\_\_\_ Child formulation \_\_\_\_\_

OR

2. Immunization (Combined hepatitis A and B vaccine)

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

OR

3. Hepatitis B surface antibody

Date \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ **Result:** Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_

#### B. MEASLES, MUMPS, RUBELLA (MMR)

(Two doses requirement at least 28 days apart for students born after 1956)

1. Dose 1 given **after 12 months** of age. .... Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2. Dose 2 given **at least 28 days after** first dose. .... Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### C. MENINGITIS (MenACYW)

(One dose is required at age 16 or older)

Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

#### D. POLIO (Primary series, doses at least 28 days apart. Three primary series are acceptable See ACIP website for details)

1. OPV alone (oral Sabin three doses) Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

OR

2. IPV/OPV sequential: IPV #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, IPV #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, OPV #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, OPV #4 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

OR

3. IPV alone (injected Salk four doses: Dose #1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #4 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

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**The following vaccines are required:**

**E. TETANUS-DIPHTHERIA-PERTUSSIS**

(Primary series with DTaP, DTP, DT, or Td, First Tdap at 11 or 12 years of age or later and booster must be within the last ten years.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:

Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose#2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose#3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose#4 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ in addition to Tdap booster below

2. Booster: within the last ten years

Tdap \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**F. VARICELLA, note 2 dose requirement**

Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, given **after 12 months** of age

Dose#2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after the first dose if age 13 years or older

OR

History of Disease Yes \_\_\_\_\_ No \_\_\_\_\_ If so, when? \_\_\_\_\_ **Health Care Professional signature:** \_\_\_\_\_

**The following vaccines are recommended:**

**A. HEPATITIS A**

- a. Immunization (hepatitis A)

Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose#2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**B. HUMAN PAPILLOMA VIRUS VACCINE (HPV)**

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) \_\_\_\_\_ 9-valent (HPV9) \_\_\_\_\_

Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose#2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**C. INFLUENZA** most recent dose \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**D. COVID-19**, most recent dose \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**E. MENINGITIS B** The vaccine series must be completed with the same vaccine.

1) MenB-RC (Bexsero) Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_, Dose #2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

2) MenB-FHbp (Trumenba) Dose#1 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose#2 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Dose #3 \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Health Care Professional**

*Please review all dates of immunizations and ensure the student has received them according to CDC/ACIP guidelines. If immunization was received off schedule, counsel student and consider additional vaccination. Please attach all immunization records to this form.*

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Printed Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Phone:** \_\_\_\_\_

