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 provider's office.*

**The following vaccine information is mandatory:**

**A. M.M.R. (MEASLES, MUMPS, RUBELLA)**
(Two doses requirement at least 28 days apart for students born after 1956 and all health sciences students.)

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

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

**B. 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_____/_____/_____

**C. VARICELLA**

1. Immunization, 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**:_____

**D. MENINGITIS (MenACYW)** **(One dose is required at age 16 or older)**

Vaccine **OR** Waiver is required of all Swarthmore College Residence Students
Date of Vaccinations:

Dose#1_____/_____/_____ Dose#2_____/_____/_____

**MENINGITIS INFORMATION RESPONSE – Required of all resident students. (Check either #1 or #2)**

1._____I have had the meningococcal meningitis (MenACYW) immunization

2._____I have read, or have had explained to me, the information regarding meningococcal meningitis disease. I understand the risks of not receiving the vaccine and have decided that I will **NOT** obtain immunization against meningococcal meningitis disease.

SIGNATURE OF STUDENT REQUIRED_____
(OR PARENT /GUARDIAN IF STUDENT IS UNDER AGE 18)

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

1. MenB-RC (Bexsero) _____routine _____outbreak-related

Dose #1_____/_____/_____ Dose #2 _____/_____/_____

**OR**

2. MenB-FHbp (Trumenba)_____routine _____outbreak-related

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

(over)

Last Name: _____ First Name: _____ Date of birth:_____

**F. HEPATITIS B**

1. Immunization (hepatitis B)

Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose#3_____/_____/_____

Adult formulation_____Child formulation_____ Adult formulation_____Child formulation_____ Adult formulation_____Child formulation_____

2. Immunization (Combined hepatitis A and B vaccinc)

Dose #1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

3. Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country and/or men who have sex with men; required for health science students).

Date_____/_____/_____ **Result**: Reactive_____ Non-reactive_____

**G. 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_____/_____/_____

**H. HEPATITIS A**

1. Immunization (hepatitis A)

Dose#1_____/_____/_____, Dose#2_____/_____/_____

2. Immunization (Combined hepatitis A and B vaccine)

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

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

Immunization (**indicate which preparation**, **if known) Quadrivalent (HPV4)_____ 9-valent (HPV9)_____**

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

**J. OTHER** If Applicable_____
**ie. TRAVEL VACCINES**

_____

_____

## Health Care Provider

***Please attach all immunization records to this form***

**Signature: _____Date: _____**

**Printed Name: _____**

**Address: _____ Phone: _____**