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)

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______/______/______

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______/______/______

F. COVID-19 The vaccine series must be completed with the same vaccine.

1. Johnson & Johnson's Janssen Dose #1_______/_______/_______
2. Moderna - two doses separated by 28 days Dose #1_______/_______/_______ Dose #2 _______/_______/_______
3. Pfizer-BioNTech - two doses separated by 21 days Dose #1_______/_______/_______ Dose #2 _______/_______/_______

(over)

Last Name: ________________________________ First Name: _____________________________ Date of birth:______________

G. 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 vaccinc)

Dose #1_______/_______/_______ Dose#2_______/_______/_______ Dose#3_______/_______/_______

OR

3. Hepatitis B surface antibody

Date_______/_______/_______ **Result**: Reactive_______ Non-reactive_______

H. 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______/______/_____

I. HEPATITIS A

1. Immunization (hepatitis A)

Dose#1______/______/______, Dose#2______/______/______

2. Immunization (Combined hepatitis A and B vaccine)

Dose#1_______/_______/_______ Dose#2_______/_______/_______ Dose#3_______/_______/_______

J. HUMAN PAPILLOMA VIRUS VACCINE (HPV)

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

Dose#1______/______/______ Dose#2______/______/______ Dose#3______/______/______

K. INFLUENZA (provide date of most recent dose) Dose#1______/______/______

L. OTHER VACCINES IF APPLICABLE:

____
____
____

Health Care Provider

*****_Please attach all immunization records to this form_

Signature: ____**Date:** _________________________

Printed Name: ____

Address: ____ **Phone:** _________________________