



RUST COLLEGE IMMUNIZATION RECORD

PART I

Name: _____

Address: _____

Telephone: _____

Emergency Contact: _____

Date of Entry ___/___/___ Date of Birth ___/___/___ Social Security Number ___/___/___-___/___/___-___/___/___

Status: 1st Time Freshman ___ Part-time ___ Full-time ___ Graduate ___ Undergraduate ___ Professional ___

PART II – TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

ACHA Guidelines (All information must be in English).

A. M.M.R. (MEASLES, MUMPS, RUBELLA)

(Two doses REQUIRED for all students at least 28 days apart for students born after 1956 and all health sciences students.)

1. Dose 1. #1 ___/___/___

2. Dose 2. #2 ___/___/___

Allergies? _____ m d y

Recommended Immunizations

B. HEPATITIS A

1. Immunization (hepatitis A)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___
m d y

C. HEPATITIS B

(All college and health sciences students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

Adult formulation ___ Child formulation ___ Adult formulation ___ Child formulation ___ Adult formulation ___ Child formulation ___

2. Immunization (Combined hepatitis A and B vaccine)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___

3. Hepatitis B surface antibody Date ___/___/___

Result: Reactive _____ Non-reactive _____

D. VARICELLA (Chicken Pox)

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

2. Varicella antibody ___/___/___ Result: Reactive _____ Non-reactive _____

3. Immunization

a. Dose #1 #1 ___/___/___

b. Dose #2 and at least 4 weeks after first dose if age 13 years or older. #2 ___/___/___

E. QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV)

(Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)

Immunization (HPV)

a. Dose #1 ___/___/___ b. Dose #2 ___/___/___ c. Dose #3 ___/___/___



F. INFLUENZA

(Trivalent inactivated influenza vaccine or TIV. Live attenuated influenza vaccine or LAIV; licensed for healthy, nonpregnant persons age 5-49 years old. **Annual immunization recommended** to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals. Health sciences students with patient contact.)

Date ____/____/____
TIV__ LAIV__ TIV__ LAIV__ TIV__ LAIV__ TIV__ LAIV__ TIV__ LAIV__ TIV__ LAIV__

G. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

(One dose for members of high-risk groups.)

Date ____/____/____
 m d y

H. MENINGOCOCCAL TETRAVALENT

(A,C,Y,W-135 / One dose — for college freshmen living in dormitories/residence halls, persons with terminal complement deficiencies or asplenia, laboratory personnel with exposure to aerosolized meningococci, and travelers to hyperendemic or endemic areas of the world. Tetravalent conjugate (preferred; data for revaccination pending; administer simultaneously with Tdap if possible): Date ____/____/____

Tetravalent polysaccharide (acceptable alternative if conjugate not available; revaccinate every 3-5 years if increased risk continues): Date ____/____/____

I. TUBERCULOSIS SCREENING

- 1. Does the student have signs or symptoms of active tuberculosis disease? Yes _____ No _____
If No, proceed to 2. If Yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.
- 2. Is the student a member of a high-risk group or is the student entering the health professions?2 Yes _____ No _____
If No, stop. If Yes, place tuberculin skin test (Mantoux only: Inject 0.1 ml of purified protein derivative [PPD] tuberculin containing 5 tuberculin units [TU] intradermally into the volar [inner] surface of the forearm.) A history of BCG vaccination should not preclude testing of a member of a high-risk group.
- 3. Tuberculin Skin Test:
Date Given: ____/____/____ Date Read: ____/____/____
Result: _____ (Record actual mm of induration, transverse diameter; if no induration, write "0")
Interpretation (based on mm of induration as well as risk factors): positive____ negative____
- 4. Chest x-ray (required if tuberculin skin test is positive) result: normal____ abnormal____
Date of chest x-ray: ____/____/____

**Part III
HEALTH CARE PROVIDER INFORMATION**

Name (please print) _____
Address _____
Telephone: _____
Signature _____