

NAME: _____
(LAST) (FIRST) (MIDDLE)

**2009 SUMMER SCHOOL
WFU STUDENT HEALTH SERVICE IMMUNIZATION RECORD (continued)
REQUIRED PRIOR TO REGISTRATION**

3. **RUBELLA:** History of disease is NOT acceptable verification. Check one (not required if 50 years old or older).

A Immunization on or after 1st birthday Date of vaccination:

(MO)	(DAY)	(YR)			

-OR-
B Report of positive immune titer..... Date:

(MO)	(DAY)	(YR)			

C. **POLIO: (not required if 18 years of age or older).**

Completed primary series: No Yes Type of vaccine: OPV IPV Last Booster Date:

(MO)	(DAY)	(YR)			

(must be on or after 4th birthday)

PART III. TUBERCULIN SKIN TEST REQUIREMENTS

A. **Tuberculin skin test within a year of university registration date if:**

- (a) the student has been exposed to tuberculosis or has signs or symptoms of tuberculosis disease or
- (b) the student's home country is *other than* United States, Australia, New Zealand, Canada, Western Europe or Japan.

Result _____ mm Date:

(MO)	(DAY)	(YR)			

B. **If POSITIVE:**

(a) Chest x-ray (required if tuberculin skin test is positive) Normal Abnormal Date:

(MO)	(DAY)	(YR)			

(b) If known to be tuberculin positive or if this test is positive, attach record of treatment.

PART IV. RECOMMENDED VACCINES

A. **Hepatitis B Vaccine** Dose #1

(MO)	(DAY)	(YR)			

 Dose #2

(MO)	(DAY)	(YR)			

 Dose #3

(MO)	(DAY)	(YR)			

B. **Varicella** Dose #1

(MO)	(DAY)	(YR)			

 Dose #2

(MO)	(DAY)	(YR)			

Report of positive immune titer History of disease Date:

(MO)	(DAY)	(YR)			

C. **Meningococcal Vaccine:** Check one (for 1st Year Undergraduates living in residence halls).

Polysaccharide (Menomune) Conjugate (Menactra)..... Date:

(MO)	(DAY)	(YR)			

D. **Quadrivalent Human Papillomavirus Vaccine (HPV)**

Dose #1

(MO)	(DAY)	(YR)			

 Dose #2

(MO)	(DAY)	(YR)			

 Dose #3

(MO)	(DAY)	(YR)			

PART V. OTHER IMMUNIZATIONS THIS STUDENT HAS RECEIVED

Pneumococcal <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>(MO)</td><td>(DAY)</td><td>(YR)</td><td></td><td></td><td></td></tr></table>							(MO)	(DAY)	(YR)				Yellow Fever <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>(MO)</td><td>(DAY)</td><td>(YR)</td><td></td><td></td><td></td></tr></table>							(MO)	(DAY)	(YR)				Hepatitis A #1 <table border="1" style="display: inline-table; vertical-align: middle;"><tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr><tr><td>(MO)</td><td>(DAY)</td><td>(YR)</td><td></td><td></td><td></td></tr></table>							(MO)	(DAY)	(YR)			
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PHYSICIAN'S NAME _____ PHONE NO: () _____

PHYSICIAN'S SIGNATURE _____

ADDRESS: _____

Return this completed form to: **Wake Forest University Student Health Service
P.O. Box 7386, Winston-Salem, NC 27109-7386
336-758-5218 <http://www.wfu.edu/shs>**