

## CALVIN COLLEGE HEALTH SERVICES IMMUNIZATION HISTORY

(Please print) Last Name, First, Middle Initial	Date of birth	Calvin ID #
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The following vaccinations are **required** for admittance to Calvin College. Please have this form completed and signed by a health care professional, **or** submit an official photocopy of your records, and send to Health Services by mail or fax .

**The deadline for this form is July 1; for late enrollments the deadline is September 1.**

### 1. TETANUS-DIPHTHERIA and PERTUSSIS

Primary series with Diphtheria, Pertussis and Tetanus (DTP) or Diphtheria and Tetanus (TD or DT) and a booster within the past ten years **required**.

DIPHTHERIA, PERTUSSIS, TETANUS or DIPHTHERIA, TETANUS	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	LATEST BOOSTER *Tdap _____ MM / DD / YYYY	_____ MM / DD / YYYY
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\*Consider Tdap for booster if last Td has been more than 5 years

### 2. POLIO

OPV (oral)  or  IPV (injected)	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY
	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY

### 3. MENINGOCOCCAL QUADRIVALENT

(vaccine must cover strains A, C, Y, W-135)

Polysaccharide Menomune (MPSV4) *Expires after 5 years	_____ MM / DD / YYYY	<b>OR</b>	Conjugate Menactra (MCV4)	_____ MM / DD / YYYY
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### 4. HEPATITIS B

Three doses of vaccine **OR** a positive Hepatitis surface antibody **OR** two-shot Hepatitis B series (Merck Recombivax HB) given between ages 11 and 15.

HEPATITIS B IMMUNIZATION	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY
HEPATITIS B MERCK RECOMBIVAX HB	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	
HEPATITIS B SURFACE ANTIBODY	_____ MM / DD / YYYY	<b>RESULT: (attach titer results)</b> _____ REACTIVE _____ NON-REACTIVE	

### 5. VARICELLA

Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart **required**.

HISTORY OF DISEASE    YES \_\_\_\_\_ NO \_\_\_\_\_

VARICELLA IMMUNIZATION	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY
VARICELLA ANTIBODY	_____ MM / DD / YYYY	<b>RESULT: (attach results)</b> _____ REACTIVE _____ NON-REACTIVE

### 6. TUBERCULOSIS:

1) If you answered NO to all the questions on the TB Self-Screening Form, the TB requirement is met.

2) **If you answered YES** to any questions on the TB Self-Screening form, a **TB Skin Test is required**. **The most common question students answer "yes" to is that they have traveled outside of North America in the last 5 years. Document below.**

TB test Date: ___/___/___    Result _____ mm Chest X-ray ( <b>Required</b> if PPD is 10 mm or greater –submit a copy of x-ray report.)    Date _____ Provider Signature _____    Result _____
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(continued)

**7. M.M.R. (Measles, Mumps, Rubella)**

Two doses of M.M.R. are **required**. Dose #1 given 1/1/71 or later and after first birthday. Dose #2 given at least 4 weeks after initial dose.

M.M.R. (MEASLES, MUMPS, RUBELLA)	#1	#2
	_____ MM / DD / YYYY	_____ MM / DD / YYYY

-----FILL OUT THIS PORTION ONLY IF M.M.R. REQUIREMENT HAS NOT BEEN MET-----

**MEASLES (Rubeola)**

If given instead of M.M.R., two doses are **required**. Dose #1 given 1/1/68 or later and **after first birthday**. (MMR is preferred for second dose – see MMR section) Dose #2 given at least 30 days after initial dose **OR** report of Immune Titer.\*

**MUMPS**

If given instead of M.M.R., two doses are **required**, given 1/1/68 or later and **after first birthday OR** report of Immune Titer.\*

**RUBELLA (German Measles)**

If given instead of M.M.R., one dose is **required** given 1/1/69 or later and **after first birthday OR** report of Immune Titer.\*

MEASLES	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	TITER RESULTS
MUMPS	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	TITER RESULTS
RUBELLA	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	TITER RESULTS

**\*Attach copy of ALL lab reports.**

**8. OTHER IMMUNIZATIONS RECEIVED**

i.e. HPV (recommended for females 11-26 years old), Hepatitis A (recommended for adolescents through age 18), Typhoid, Yellow Fever, Twinrix, etc.

	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY
	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY
	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY
	#1 _____ MM / DD / YYYY	#2 _____ MM / DD / YYYY	#3 _____ MM / DD / YYYY	#4 _____ MM / DD / YYYY	#5 _____ MM / DD / YYYY

<b>REQUIRED HEALTH CARE PROFESSIONAL'S SIGNATURE</b> (Physician, Nurse, Health Dept. Stamp – <b>not immediate family member</b> ):	
Print name _____	Address _____
Signature _____	Date ____/____/____ Phone ( ) _____