

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.

TETANUS-DIPHTHERIA and PERTUSSIS - REQUIRED

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
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*Consider Tdap for booster if last Td has been more than 5 years

POLIO - REQUIRED

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

M.M.R. (Measles, Mumps, Rubella) - REQUIRED

Two doses M.M.R. **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 MM / DD / YYYY	#2 MM / DD / YYYY
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-----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 **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 **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 **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.

MENINGOCOCCAL - REQUIRED

Polysaccharide Menamune (MPSV4) *Expires after 5 years	MM / DD / YYYY	OR	Conjugate Menactra (MCV4)	MM / DD / YYYY
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(continued)

HEPATITIS B - REQUIRED

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	RESULT: (attach titer results) _____ REACTIVE _____ NON-REACTIVE	

VARICELLA - REQUIRED

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	RESULT: (attach results) _____ REACTIVE _____ NON-REACTIVE

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 they have traveled outside of North America in the last 5 years. Document below.

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

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

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