SEATTLE UNIVERSITY

IMMUNIZATION RECORD VERIFICATION BY A HEALTH CARE PROFESSIONAL

(This form is NOT required if you have documentation of required immunizations which can be uploaded directly to the patient portal. Forms must be in English or translated to English to be verified compliant)

PART I			
Name	First Name		
Address Street Date of Entry / Date of Birth / Y Date of Birth / Y	City School ID#	State	Zip Code
PART II - TO BE COMPLETED AND SIGNED B	BY YOUR HEALTH CA	RE PROVIDER.	
<u>REQUIRED IMMUNIZATIONS</u> COVID-19 VACCINE – <i>REQUIRED OF ALL STUDEN</i>	UTC		
		, , ,	
Dose # 1 Vaccine name/Manufacturer:			
Dose # 2 Vaccine name/Manufacturer:		//	
Dose #3/Booster Vaccine name/Manufacturer		_	
Dose #3/Booster Vaccine name/Manufacturer:			
Dose #4/Booster Vaccine name/Manufacturer:			
(Two doses required at least 28 days apart for students bot Dose # 1 (given at age 12-15 months or later)	n after 1956 and all health car	re professional students	
	□ MM □ MR	M D Y	
Dose # 2 (given at age 4-6 years or later, and at least one month after f		/	-
Vaccine given: □ MMR □ MMRV □ ME	□ MM □ MR	M D I	
OR			
	□ Non-reactive (negative)	// 	
HEALTH CARE PROVIDER			
Name and title of Health care Practitioner			
Health care Practitioner's signature		Date signed	
Address:		5	
Phone: Fax:			

PART III: OPTIONAL

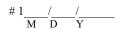
RECOMMENDED IMMUNIZATIONS (recommended by the Advisory Committee on Immunization Practices and the American College Health Association. NOT REQUIRED.

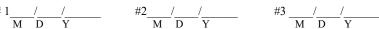
1. TETANUS, DIPHTHERIA, WITH OR WITHOUT PERTUSSIS

Tdap booster recommended for ages 11 – 64 unless contraindicated.

2. HEPATITIS B (All college and health care professional students. Three doses of vaccine or a positive hepatitis B surface antibody meets the requirement.)

A. Immunization





OR

B. Hepatitis B surface antibody

☐ Reactive (positive)

☐ Non-reactive (negative)

3. HEPATITIS A

A. Immunization

$$\# 1$$
 $$\frac{}{M} \frac{}{D} \frac{}{Y}$ $$\# 2$ $$\frac{}{M} \frac{}{D} \frac{}{Y}$ $$Y$$$$$

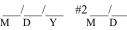
4. POLIO (Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

A. OPV alone (oral Sabin three doses):.... #

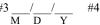
1	/	/	
M	D	Y	

OR

B. IPV alone (injected Salk four doses):......#1 $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$





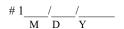


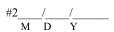


OR

5. VARICELLA (Chicken Pox) (History of chicken pox, a positive varicella antibody, or two doses of vaccine)

A. Immunization





OR

B. Varicella antibody

☐ Reactive (positive) ☐ Non-reactive (negative)



C. History of disease



6.	MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135) One dose or 2 doses for all college students – revaccinate every 5 years
	if increased risk continues

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible)

OR

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available)

Date $\frac{}{M}$ $\frac{}{D}$ $\frac{}{Y}$

7. MENINGOCCOCAL SEROGROUP B (Two or three dose series; may be given to any college student or for outbreak control)

1. MenB-RC (Bexsero)

 $\#1_{\overline{M}}$ $\frac{/}{D}$ $\frac{/}{Y}$ #2 $\frac{/}{M}$ $\frac{/}{D}$ $\frac{/}{Y}$

2. MenB-FHbp (Trumenba)

8. INFLUENZA

Date of last dose: ___/__/___/

PNEUMOCOCCAL POLYSACCHARIDE VACCINE (One dose for members of high-risk groups)

PCV 13

Date $\frac{}{M}$ $\frac{}{D}$ $\frac{}{Y}$

PPSV 23

Date __/__/____

10. HUMAN PAPILLOMA VIRUS (three doses of vaccine)

 $#1 _{M} /_{M} /_{D} /_{Y}$ $#2 _{M} /_{D} /_{Y}$ $#3 _{M} /_{D} /_{Y}$

Vaccine given:

☐ Gardasil 4 (HPV4) ☐ Gardasil 9 (HPV9) ☐ Cervarix (HPV2)

HEALTH CARE PROVIDER

Name and title of Health care Practitioner

Health care Practitioner's signature

Date signed