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	City	State	Zip Code
Date of Entry/ Date of Birth/ D	Y School ID#		
PART II - TO BE COMPLETED AND SIGNE	D BY YOUR HEALTH CAI	RE PROVIDER.	
REQUIRED IMMUNIZATIONS			
MEASLES VACCINATION - REQUIRED OF A	LL STUDENTS TAKING UND	ERGRADUATE CLAS	SES
(Two doses required at least 28 days apart for student	ts born after 1956 and all health ca	are professional students.))
Dose # 1 (given at age 12-15 months or later)			
Vaccine given: □ MMR □ MMRV □ ME	$\hspace{0.1cm} \hspace{0.1cm} \hspace$	Month Day	 Year
		Monin Day	ieur
Dose # 2 (given at age 4-6 years or later, and at least	one month after first dose)		
Vaccine given: □ MMR □ MMRV □ ME	□ MM □ MR □	<u> </u>	W
		Month Day	Year
OR			
	NT (
Measles surface antibody □ Reactive (positive)	□ Non-reactive (negative	${Month} {Day}$	Year
HEALTH CARE PROVIDER			
Name and title of Health care Practitioner			
Health care Practitioner's signature		Date signed	
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Address:	· · · · · · · · · · · · · · · · · · ·		
Phone: Fax:			

PART III: OPTIONAL

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

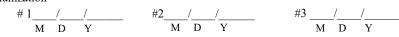
1	TETANUS	DIPHTHERIA	WITH OR WITHOUT PERTUSSIS
1.	ILIANUS,	DIFTITENIA,	WITH OR WITHOUT FERT USSIS

 $\Box \text{ No} \qquad \text{Date of last dose in series: } \underline{\frac{}{M} \underline{\frac{}{D} \underline{Y}}}$ □ Yes Primary series completed?

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) $\frac{1}{M} \frac{1}{D} \frac{1}{V}$

3. HEPATITIS A

A. Immunization

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

OR

B. IPV alone (injected Salk four doses):.....# 1 $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ #2 $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ #3 $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$ #4 $\frac{1}{M}$ $\frac{1}{D}$ $\frac{1}{Y}$

C. IPV/OPV sequential:.....IPV #1 / / / Y IPV #2 / / / Y OPV #3 / / / OPV #4 / / / Y

COVID-19 VACCINE

Vaccine name/Manufacturer:____/____ Vaccine name/Manufacturer:_____/ Vaccine name/Manufacturer: /

Vaccine name/Manufacturer:_____/ $\frac{1}{M}$

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

A. Immunization

(at least 12 weeks after first dose if ages 1-12 y.o. #1___/__/___ #2___/__/____ and at least 4 weeks after first dose if age 13 or older)

OR

B. Varicella antibody □ Reactive (positive) □ Non-reactive (negative) C. History of disease

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

A. Quadrivalent conjugate (preferred)



OR

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

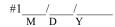
Date $\frac{}{M}$ $\frac{}{D}$ $\frac{}{Y}$

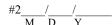
8. MENINGOCCOCAL SEROGROUP B (Two or three dose series; may be given to any college student or for outbreak control)

A. MenB-RC (Bexsero)



B. MenB-FHbp (Trumenba)





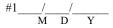
9. INFLUENZA

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

PCV 13

PPSV 23

10. HUMAN PAPILLOMA VIRUS (three doses of vaccine)



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