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 _____ _____
Last Name *First Name*

Address _____
Street *City* *State* *Zip Code*

Date of Entry ____/____ (M Y) Date of Birth ____/____/____ (M D Y) School ID# _____

PART II - TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

REQUIRED IMMUNIZATIONS

COVID-19 VACCINE – *REQUIRED OF ALL STUDENTS*

Dose # 1 **Vaccine name/Manufacturer**: _____ ____/____/____ (M D Y)

Dose # 2 **Vaccine name/Manufacturer**: _____ ____/____/____ (M D Y)

Dose #3/Booster **Vaccine name/Manufacturer**: _____ ____/____/____ (M D Y)

Dose #4/Booster **Vaccine name/Manufacturer**: _____ ____/____/____ (M D Y)

MEASLES VACCINATION - *REQUIRED OF UNDERGRADUATE STUDENTS ONLY*

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

Dose # 1 (given at age 12-15 months or later) ____/____/____ (M D Y)

Vaccine given: ☐ MMR ☐ MMRV ☐ ME ☐ MM ☐ MR

Dose # 2 (given at age 4-6 years or later, and at least one month after first dose) ____/____/____ (M D Y)

Vaccine given: ☐ MMR ☐ MMRV ☐ ME ☐ MM ☐ MR

OR

Measles surface antibody ☐ Reactive (positive) ☐ Non-reactive (negative) ____/____/____ (M D Y)

HEALTH CARE PROVIDER

_____
Name and title of Health care Practitioner

_____ _____
Health care Practitioner's signature *Date signed*

Address: _____

Phone: _____ *Fax:* _____

_____
Students name

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

Primary series completed? ☐ Yes ☐ No Date of last dose in series: ____/____/_____
M D Y

Date of most recent booster: ____/____/_____ Type of booster: ☐ Td ☐ Tdap
M D Y

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

1____/____/_____ #2____/____/_____ #3 ____/____/_____
M D Y M D Y M D Y

OR

B. Hepatitis B surface antibody ☐ Reactive (positive) ☐ Non-reactive (negative) ____/____/_____
M D Y

3. HEPATITIS A

A. Immunization

1 ____/____/____ #2 ____/___/___
M D Y M D 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 ___/___/_____ #2 ___/___/_____ #3 ___/___/_____
M D Y M D Y M D Y

OR

B. IPV alone (injected Salk four doses):……# 1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___
M D Y M D Y M D Y M D Y

OR

C. IPV/OPV sequential:……IPV #1___/___/___ IPV #2 ___/___/___ OPV #3 ___/___/___ OPV #4 ___/___/___
M D Y M D Y M D Y M D Y

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

A. Immunization

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

OR

B. Varicella antibody ☐ Reactive (positive) ☐ Non-reactive (negative) ____/____/_____
M D Y

C. History of disease ____/____/_____
M D Y

_____
Students name

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)

#1 ___/___/_____ (M D Y) #2 _____/____/_____ (M D Y)

OR

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

Date ____/____/____ (M D 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___/___/_____ (M D Y) #2 _____/____/_____ (M D Y)

OR

2. MenB-FHbp (Trumenba)

#1____/____/_____ (M D Y) #2____/____/_____ (M D Y) #3 (if needed) ____/____/_____ (M D Y)

8. INFLUENZA

Date of last dose: ___/___/_____ (M D Y)

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

PCV 13 Date ___/___/_____ (M D Y)

PPSV 23 Date ___/___/_____ (M D Y)

10. HUMAN PAPILLOMA VIRUS (three doses of vaccine)

#1____/____/_____ (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*