Keene State College
Center for Health and Wellness
229 Main St MS 2802
Keene, NH 03435
603-358-2450 603-358-2444 (fax)

Immunization Record

PART I

Name _____ _____
First Name Middle Name

_____
Last Name

Address _____
Street City State Zip

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

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____ Professional _____

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

All information must be in English.

Required Immunizations

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after 1956)

1. Dose 1 given at age 12 months or later . ..... #1 ____/____/_____
M D Y
2. Dose 2 given at least 28 days after first dose ..... #2 ____/____/_____
M D Y

B. POLIO

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

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____
M D Y M D Y M D Y
2. IPV/OPV sequential: IPV #1 ____/____/_____ IPV #2 ____/____/_____ OPV #3 ____/____/_____ OPV #4 ____/____/_____
M D Y M D Y M D Y M D Y
3. IPV alone (injected Salk four doses): #1 ____/____/_____ #2 ____/____/_____ #3 ____/____/_____ #4 ____/____/_____
M D Y M D Y M D Y M D Y

C. VARICELLA

(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___
2. Varicella antibody ____/____/_____ Result: Reactive _____ Non-reactive _____
M D Y
3. Immunization
   a. Dose #1 ..... #1 ____/____/_____
   M D Y
   b. Dose #2 given at least 12 weeks after first dose ages 1-12 years. ..... #2 ____/____/_____
   and at least 4 weeks after first dose if age 13 years or older. M D Y

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___

   Date of <u>last</u> dose in series: ____/____/_____
   M D Y
2. Date of most recent booster dose: ____/____/_____
   M D Y

   Type of booster: Td _____ Tdap _____

   Tdap booster recommended for ages 11-64 unless contraindicated.

E. MENINGOCOCCAL QUADRIVALENT

(A, C, Y, W-135) One 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).

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

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

   Date ____/____/_____ (M D Y)

Recommended Immunizations

F. INFLUENZA

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

Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

G. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

H. HEPATITIS B

(Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

   b. Dose #2 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

   c. Dose #3 ____/____/_____ (M D Y) Adult formulation ____ Child formulation ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

3. Hepatitis B surface antibody Date ____/____/_____ (M D Y) Result: Reactive _____ Non-reactive _____

I. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

(One dose for members of high-risk groups.)

Date ____/____/_____ (M D Y)

J. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)

(Three doses of vaccine for female or male college students 11-26 years of age at 0, 1/2, and 6 month intervals.)

Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____

a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)