Immunization Form

Immunization history is required by the State of New Hampshire and will be required for REGISTRATION. **Please have health care provider complete immunization record.**

Student_____ Social Security Number _____
(please print)

Date of Birth _____

Required for all students

A. MMR (Measles, Mumps, Rubella) 2 doses required ____Dose 1 – Immunization after 12 months Date____/_____/_____

____Dose 2 – Immunization after 5 years or later Date____/_____/_____

Recent titers to verify status of protection are required for students who are unable to provide documentation of MMR immunization. **Enclose of copy of titer results.**

B. TUBERCULIN TEST (required if high risk: see Tuberculosis Risk Questionnaire)

____PPD (Mantoux) test within the past year Results: mm _____ Induration Date____/_____/_____
(Tine or monovac not acceptable) *Must be read by MD, ARNP, PA, RN 48-72 hrs. after receiving

____Positive PPD – Chest x-ray required X-Ray Result: ____Positive ____Negative Date____/_____/_____

Treatment type*_____ Duration_____

*Please provide MD report or current or past treatment

Strongly recommended for all students

C. VARICELLA (Chicken pox) ____Had Disease Date____/_____/_____

____Varivax: 2 doses 4-8 weeks apart Date____/_____/_____

D. MENINGOCOCCAL ____ Type of vaccine_____ Date____/_____/_____

E. DIPTHERIA/TETANUS/PERTUSSIS ____Complete primary series (DTP, DTap) Date____/_____/_____

____Received TD booster within last 10 years Date____/_____/_____

____Tdap Date____/_____/_____

F. POLIO ____Completed primary series ___oral ___IPV Date____/_____/_____

G. HEPATITIS B ____ Completed vaccination series: Dose 1 Date____/_____/_____

Dose 2 Date____/_____/_____

Dose 3 Date____/_____/_____

____ Has report of positive immune titer (include copy) Date ____/_____/_____

H. HPV (if female) ____ Completed vaccination series Dose 1 Date____/_____/_____

Dose 2 Date____/_____/_____

Dose 3 Date____/_____/_____

Health Care Provider (MD, ARNP, PA or RN)

MD/ARNP, PA, RN (print)_____ Date____/_____/_____

ADDRESS_____ Tel:_____

SIGNATURE_____

●Center for Health & Wellness, Keene State College, Elliot Hall 3rd. Floor, 229 Main St. Keene, NH 03435-2802●