

Immunization History Form

****Please allow 24-48 hours to be processed. Check your Gulfline account to verify your immunization status.****

Name: Last		First	MI
University ID # 8 1 4 _ _ _ _ _		Date of Birth _ _ / _ _ / _ _	Age
Permanent Address			
City	State	Zip Code	Phone ()

STATE REQUIRED	Vaccination	Month/Day/Year	Month/Day/Year	Month/Day/Year	
	MMR <small>1st vaccine must be given after 12 months of age; must be in 1969 or later; 2nd dose must be at least 28 days after 1st dose</small>	/ /	/ /	<small>*The Measles, Mumps, and Rubella vaccines can be substituted with two MMR vaccines OR positive Rubella/Rubeola titers (must submit laboratory results indicating immunity)</small>	
	MEASLES <small>1st dose in 1968 or later; 2nd dose at least 28 days after 1st</small>	/ /	/ /		
	MUMPS	/ /	/ /		
	RUBELLA	/ /	/ /		
	HEPATITIS B <small>Series of 3 vaccinations * OR sign waiver below</small>	/ /	/ /	/ /	/ /
MENINGOCOCCAL <small>Please indicate which meningitis vaccine was given * OR sign waiver below</small>	/ / Menactra® (MCV4)	/ / Menveo® (MCV4)	/ /	/ / Menomune® (MPSV4)	

RECOMMENDED NOT MANDATORY	Vaccination	Month/Day/Year	Month/Day/Year	Notes
	Hepatitis A	/ /	/ /	
	Hepatitis A & B Combined	/ /	/ /	/ /
	Human Papillomavirus	/ /	/ /	/ /
	PPD <small>Date placed</small>	/ /	/ / <small>Date Read</small>	<small>Result: _____ mm induration Positive () Negative ()</small>
	Tetanus Diphtheria <small>Please indicate which tetanus vaccine was given</small>	/ / TD	/ / Adacel® Tdap	/ / Boostrix® Tdap
Varicella <small>Series of 2 vaccinations</small>	/ /	/ /	<small>Incidence of Disease Date:</small>	

An official stamp from a doctor's office, clinic, or health department AND an authorized signature must appear below or this form WILL NOT be accepted

Official office stamp

Physician or Authorized Signature

Date

WAIVER OPT-OUT	<p>If you have not completed the Hepatitis B series or received the Meningitis vaccine, please <u>check</u> the corresponding box below.</p>
	<p><input type="checkbox"/> I have read the information regarding Hepatitis B and I decline receipt of the vaccine.</p> <p><input type="checkbox"/> I have read the information regarding Meningococcal Meningitis and I decline receipt of the vaccine.</p>
	<p>_____ Signature of Student (or parent/guardian if under 18)</p> <p>_____ Date</p>