

University of Hartford, Student Health Services

200 Bloomfield Avenue ♦ West Hartford, CT 06117 ♦ Phone: (860) 768-6601 Fax: (860) 768-5140

IMMUNIZATION RECORD

Name: _____ Address: Street: _____
 UHA ID#: _____ SS# _____ City: _____
 Date of Birth: _____ Male ___ Female ___ State: _____ Zip _____
 Student # (Cell) _____ Phone (Home) _____
 Status: Will be living in campus housing? Yes No Date Entering University: _____
 Full-Time Part-Time Graduate Program Freshman Sophomore Junior Senior

Measles Vaccine: *First dose* must have been administered on or after the student's first birthday, AND must have been administered on or after 1/1/69. The *second dose* must have been administered on or after 1/1/80. (*Exempt if born before 12/31/56*)

Mumps Vaccine: Must have been administered on or after the student's first birthday.

Rubella (German Measles) Vaccine: Must have been administered on or after the student's first birthday.

▶ **REQUIRED IMMUNIZATIONS** ◀

This section must be completed by either a physician or someone operating under the direction of a physician, i.e., school nurse, PA, APRN. Record of Immunizations (month/day/year)

Disease History <i>IS NOT</i> acceptable	1 st dose (or 1 st MMR)	2 nd dose (or 2 nd MMR)	Lab evidence of immunity—titer is acceptable Date of test	Titre Results
Measles				
Mumps				
Rubella				
Meningitis Vaccine <i>Required for all students living in campus housing</i>			Date: _____	

Tuberculosis Screening: (BCG Vaccine is not a contraindication to testing.)

Test date must be completed within the last calendar year.

PPD (Mantoux) Date: ___/___/___ Results: Negative Positive Induration ___ mm

Chest x-ray (if positive PPD) Date: ___/___/___ Results: Negative Positive

If positive PPD, treatment with _____ Dates: _____

NON-REQUIRED, BUT STRONGLY RECOMMENDED IMMUNIZATIONS

Hepatitis A Vaccine Date 1: ___/___/___ Date 2: ___/___/___
 Hepatitis B Vaccine Date 1: ___/___/___ Date 2: ___/___/___ Date 3: ___/___/___
 Varicella Date 1: ___/___/___ Date 2: ___/___/___
 Tetanus Diphtheria Date: ___/___/___

Date of Last Physical Examination: _____ *(a physical is not required but strongly recommended)*

Signature of Health Care Provider: (MUST BE SIGNED OR STAMPED BY HEALTHCARE PROVIDER)

Name: _____ Signature: _____

Address: _____ Phone: () _____