**Lehigh University Health & Wellness Center**

**IMMUNIZATION RECORD**

LAST NAME, FIRST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LEHIGH ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_ ENTERING SEMESTER Fall 20\_\_\_ M D Y

**THIS FORM MUST BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER. PLEASE REMEMBER THAT THESE DATES MUST BE INPUTTED IN *ONLINE STUDENT HEALTH (OSH)* PRIOR TO MAILING TO THE HEALTH & WELLNESS CENTER. *Please complete in black or blue ink.***

**MENINGOCOCCAL**

***Pennsylvania State Law requires ALL students residing in campus housing either be vaccinated against meningitis OR sign a waiver declining vaccination after reviewing information about the benefits of the vaccine.***

MCV4 *at least one dose after 16th birthday* \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**AND**

At least one dose of MenB (*Bexsero* or *Trumenba*)date of most recent dose: **\_\_\_\_/\_\_\_\_/\_\_\_\_**

**Please circle one** M D Y

**Please check to indicate that you have reviewed the Meningitis information on** [**www.lehigh.edu/health**](http://www.lehigh.edu/health)**/ and have decided not to obtain a vaccination against meningococcal disease.**

**I am waiving : \_\_\_\_\_\_**  MCV4 **\_\_\_\_\_\_**  MenB

**Please reserve the following for me to receive on move-in day** MCV4**\_\_\_\_\_\_\_** *Bexsero***\_\_\_\_\_\_***Trumemba\_\_\_\_\_\_*

**I understand that I will be able to receive either of these vaccines on campus if I change my mind. I may also continue the MenB series at Lehigh.**

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(student or parent/guardian, if student is under the age of 18 years):

Print Name of Student: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**VARICELLA (Chicken Pox) *Required***

(Birth in the U.S. before 1980, a history of chicken pox, a reactive varicella antibody titer ***or*** **2** doses of the vaccine)

1. History of Disease: Date \_\_\_\_/\_\_\_\_ *or* Birth in U.S. before 1980 Yes \_\_\_\_ No \_\_\_\_

M Y

2. Varicella Antibody: Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Reactive \_\_\_\_ Non-Reactive \_\_\_\_

3. Immunization: Dose 1: #1\_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

Dose 2 (given at least 12 weeks after first dose ages 1-12 years #2\_\_\_\_/\_\_\_\_/\_\_\_\_

*or* at least 4 weeks after first dose if age 13 years or older): M D Y

**LAST NAME, FIRST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LEHIGH ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**MMR (Measles, Mumps, Rubella) *Required***

Dose 1 (given at age 12 months or later): #1 \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

Dose 2 (given at least 28 days after first dose): #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**Tdap (*Adacel* or *Boostrix*) *Required* \_\_\_\_/\_\_\_\_/\_\_\_\_** M D Y

Td booster within the last ten years if Tdap is over 10 years ago

(Please check here if □ Td *only* due to reaction to pertussis) \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**HEPATITIS B *Required***

(3 doses of vaccine ***or*** a reactive Hepatitis B surface antibody titer)

1. Hepatitis B Surface Antibody (HepBsAb): Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Reactive\_\_\_\_ Non-Reactive\_\_\_\_

M D Y

2. Hepatitis B vaccine: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y M D Y M D Y

**POLIO *Required***

Date primary Series (OPV or IPV) completed: \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**FLU VACCINE *Recommended Annually***

(Date of last vaccine): \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**HUMAN PAPILLOMAVIRUS VACCINE *Recommended***

Quadrivalent (*Gardasil*)*or*  #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_/\_\_\_\_

(*Gardasil9*) M D Y M D Y M D Y

**HEPATITIS A *Recommended***

Hepatitis A vaccine: #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y M D Y

**PNEUMOCOCCAL POLYSACCHARIDE VACCINE *Recommended***

(Indicated for high-risk groups; includes smokers and individuals with asthma): \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y

**OTHER**

BCG: \_\_\_\_/\_\_\_\_/\_\_\_\_ Typhoid: \_\_\_\_/\_\_\_\_/\_\_\_\_ Yellow Fever: \_\_\_\_/\_\_\_\_/\_\_\_\_

M D Y M D Y M D Y

**\*Note: TB Questionnaire cannot be waived and must be completed on OSH.**

**HEALTH CARE PROVIDER:**

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **PLEASE RETURN COMPLETED FORM TO:**

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Lehigh University Health & Wellness Center

36 University Drive

Fax \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Bethlehem, PA 18015

P 610.758.3870

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ F 610.758.5833

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_