

IMMUNIZATION RECORD

This form, including the Immunization Record on the front and the Tuberculosis Screening on the back, must be completed and signed by a health care provider.

REQUIRED VACCINES

Vaccines	Dates Given	Vermont State Requirements
Tdap or Td	Tdap ____ Td ____ #1 ___/___/___	1 Tdap/Td booster within last 10 years
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	2 doses or positive titers Minimum of 4 weeks between doses 1 st dose given after 1 st birthday Option of combined MMR OR individual vaccines
Measles	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Mumps	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Rubella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	
Meningococcal	#1 ___/___/___ <input type="checkbox"/> Menomune <input type="checkbox"/> Menactra	One dose for first year students living in campus-based housing
Varicella	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ History of disease <input type="checkbox"/> No <input type="checkbox"/> Yes Date ___/___/___ <small>mo yr</small>	2 doses varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age 13 or older
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___	3 doses or positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (16 weeks between doses 1 and 3)

OPTIONAL VACCINES

Vaccines	Dates Given	Recommendations
Polio	Primary series: <input type="checkbox"/> Oral <input type="checkbox"/> Injectable Most recent booster: ___/___/___	Primary series
Hib	#1 ___/___/___	Primary series
Hepatitis A	#1 ___/___/___ #2 ___/___/___	Recommended if planning to travel 6-12 months between doses 1 and 2
Influenza	Most recent: ___/___/___	Recommended annually ___/___/___ ___/___/___
Pneumococcal	#1 ___/___/___ <input type="checkbox"/> Polysaccharide (PPV) <input type="checkbox"/> Conjugate (PCV)	Chronic health problems
Rabies	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Travel / occupational
Yellow Fever	#1 ___/___/___	Travel
Typhoid		Travel
HPV (women)	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	Health care maintenance

TUBERCULOSIS SCREENING

- Has the student lived in any of the countries with high rates of TB (table below)? Yes No
- Has the student been in close contact with someone with tuberculosis? Yes No
- Has the student resided or worked in a prison, homeless shelter, nursing home or hospital? Yes No
- Does the student have cancer, leukemia, diabetes, kidney disease, HIV/AIDS, low body weight, malabsorption syndrome, history of IV drug use or take immunosuppressive meds such as prednisone? Yes No

PPD (Mantoux) skin test is required if any of the above answers is YES. A history of BCG vaccination does not preclude testing.

Date Placed: _____ Date Read: _____ Result: _____ mm of induration

Chest X-ray required if the tuberculin skin test is positive:

Date of x-ray: _____ Result: Normal Abnormal

Countries with High Rates of TB				
Afghanistan	Columbia	India	Mongolia	Sierra Leone
Angola	Comoros	Indonesia	Morocco	Solomon Islands
Armenia	Congo	Iran	Mozambique	Somalia
Azerbaijan	Congo DR	Kazakhstan	Myanmar	South Africa
Bahamas	Cote d'Ivoire	Kenya	Namibia	Sri Lanka
Bahrain	Croatia	Kiribati	Nepal	Sudan
Bangladesh	Djibouti	Korea DPR	New Caledonia	Suriname
Belarus	Dominican Republic	Korea, Rep	Nicaragua	Swaziland
Benin	Ecuador	Kyrgyzstan	Niger	Syrian Arab Republic
Bhutan	El Salvador	Laos	Nigeria	Tajikistan
Bolivia	Equatorial Guinea	Lao PDR	Niue	Tanzania UR
Bosnia	Eritrea	Latvia	North Mariana Is	Taiwan
Botswana	Estonia	Lesotho	Palau	Thailand
Brunei Darussalam	Gabon	Lithuania	Panama	Tokelau
Burundi	Gambia	Macedonia TFYR	Papua New Guinea	Turkmenistan
Cambodia	Georgia	Madagascar	Paraguay	Uganda
Cameroon	Ghana	Malawi	Peru	Ukraine
Cape Verde	Guam	Malaysia	Philippines	Uzbekistan
Central African Republic	Guatemala	Maldives	Portugal	Vanuatu
Chad	Guinea	Mali	Romania	Viet Nam
China	Guinea-Bissau	Marshall Islands	Russian Federation	Yemen
China Hong Kong SAR	Guyana	Mauritania	Rwanda	Zambia
China Macao SAR	Haiti	Mauritius	Sao Tome & Principe	Zimbabwe
	Honduras	Micronesia	Senegal	
		Moldova, Rep		

HEALTH CARE PROVIDER _____	SIGNATURE _____
PRINT	
ADDRESS _____	
TELEPHONE _____	FAX _____
DATE _____	