IMMUNIZATION RECORD

Required of all students

Name____ SID ____________________
Last *First* *MI* *Preferred Name*

Address ____
Street *City* *State* *ZIP*

Date of Birth____/____/________ Female Male Cell Phone (______) ________________________

Enrolling Year _______ Fall Jan Term Spring Summer

M.M.R. (Measles, Mumps and Rubella)
(No immunization required if born before 1957)

M.M.R. (Measles, Mumps, Rubella)	#1 ____________ month/ day/ year	#2 ____________ month/day/year

OR

MEASLES (Rubeola) two doses required OR positive immune titer*
MUMPS one dose required OR report of positive immune titer*
RUBELLA one dose required OR report of positive immune titer*

Measles	#1 ______________ month/day/year	#2 ______________ month/day/year	Titer results and date ______________ *attach report copy
Mumps	#1 ______________ month/day/year	Titer result and date *attach report copy ______________	
Rubella	#1 ______________ month/day/year	Titer result and date ______________ *attach report copy	

TETANUS-DIPHTHERIA PERTUSIS
Vaccination must be within the last 10 years

Tdap ______________ month/day/year	**OR**	Td ________________ month/day/year

TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease? Yes No **If no,** proceed to 2.
If yes, proceed with additional evaluation to exclude active tuberculosis disease, including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high-risk group* or is the student entering a health profession? Yes No **If no,** stop. **If yes,** proceed to 3.

3. PPD Skin Test (Mantoux) within the last 12 months
Date Given______________ Date Read_____________ Results (mm induration) _________________________ **If positive,** proceed to 4.
month/day/year month/day/year

4. Chest x-ray (required if PPD is positive) Date _______________ Normal Abnormal

*High-risk students include those who have arrived within the past 5 years from any country EXCEPT Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

REQUIRED OF ALL FRESHMEN LIVING ON CAMPUS

VARICELLA (Chickenpox)

Date of Disease	____________ month/year	
OR Immunization	#1 ____________ month/day/year	#2 ____________ month/day/year

MENINGOCOCCAL

Immunization	____________ month/day/year

REQUIRED OF ALL PHARMACY, NURSING AND ATHLETIC TRAINING STUDENTS *(Recommended for all students)*

HEPATITIS B vaccination or titer

#1 ____________ month/day/year	#2 ____________ month/day/year	**#3** ____________ month/day/year

OR

Hepatitis B Surface Antibody	____________ month/day/year	Reactive Nonreactive

THIS RECORD MUST BE SIGNED BY A HEALTH-CARE PROVIDER (Health Department stamp is acceptable)

MD/PA/NP/RN Signature ______________________________ Date ________________________

Print Name____ Phone (_______) ________________

Address ____

COMPLETE AND RETURN TO Student Health Services, Samford University, 800 Lakeshore Drive, Birmingham, AL 35229.

Keep a copy for your records.