NAME (PRINT) _____ DATE OF BIRTH _____

PART B - IMMUNIZATION RECORDS: TO BE COMPLETED BY HEALTH CARE PROVIDER

Please note: all of the requirements below apply to ALL students – full time, undergraduate, graduate and commuter unless noted otherwise.

This form must be completed and signed by a health care provider (physician, PA, CRNP) unless there is a copy of an official immunization record attached.

Required Immunizations:

MMR (Measles/Mumps/Rubella: Two doses First dose on or after 1st birthday OR Lab immunity	Dose #1	Dose #2	
	Lab Immunity date Please attach report		
Varicella: Vaccination OR Lab immunity	Dose #1	Dose #2	
	Lab Immunity date Please attach report		
Meningitis: ACWY (within 5 years)	Date #1	Date #2	
Tdap: (within 10 years)	Date		

Recommended:

****COVID-19 vaccination** ***You must upload a copy of your Covid vaccination card into your health portal**	Dose #1 □ Moderna □ Pfizer □ Janssen (J&J) □ Other	Dose #2 □ Moderna □ Pfizer □ Janssen (J&J) □ Other	Booster □ Moderna □ Pfizer □ Janssen (J&J) □ Other
Hepatitis B: Three doses OR Lab immunity	Dose #1	Dose #2	Dose #3
	Lab Immunity date Please attach report		
Polio Series:	Dose #1	Dose #2	Dose #3 / Dose #4
Polio adult booster: age 16+	Date		
HEPATITIS A:	Dose #1	Dose #2	
HPV VACCINE:	Dose #1	Dose #2	Dose #3
MENINGITIS B:	Dose #1	Dose #2	Dose #3 (IF Trumenba)

**** Required for Undergrad Nursing, OT and PT Grad Programs. Also required for Messiah University sponsored travel.**

TRAVEL VACCINES (not required) Please list dates if received.

Typhoid: □ Typhim or □ Vivotif Dose #1 _____ (mo/day/yr) Dose #2 _____ (mo/day/yr)	**Miscellaneous Vaccines (not listed above)** Vaccine name _____ Date given _____ (mo/day/yr) Vaccine name _____ Date given _____ (mo/day/yr) Vaccine name _____ Date given _____ (mo/day/yr)
Yellow fever: _____ (mo/day/yr)	

PHYSICIAN INFORMATION

Healthcare provider signature _____ Date _____

Print last name _____ Phone _____

Address _____ Fax _____