**Student Health Center IMMUNIZATION RECORD**

**11300 NE 2nd Avenue**

**Miami Shores, FL. 33161**

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StudentName\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date of Birth \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ School ID # or Social Security#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**THE FORM BELOW IS TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.**

**Acceptable records of immunizations may also be obtained from the other sources that are listed on** [www.barry.edu/healthServices/requiredHealth](http://www.barry.edu/healthServices/requiredHealth)

**PART A.** *The immunizations listed below are* ***REQUIRED*** *for all students residing in campus housing or attending the University on an F1 or J1 Visa:*  ***All information must be in English ( example: month/day/year).***

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| M.M.R. (Measles, Mumps, Rubella) Dose #1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (Two doses required at least 28 days apart for students born after 1956)  *If given separately: OR*  Measles Dose #1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ *OR* Titer date and results \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ € Immune € Not Immune  Mumps Dose #1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ *OR* Titer date and results \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ € Immune € Not Immune Rubella Dose #1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ *OR* Titer date and results \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ € Immune € Not Immune  (*Please attach lab results*) |
| TETANUS-DIPHTHERIA-PERTUSSIS (booster with Tdap *OR* Td within the last ten years required)   1. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td,   depending on age of patient. (Administer with MCV4 simultaneously is possible)……………………………………………………………… \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  2. Booster: Td within the last ten years…….…………………………………………………………………………………………………………………………... \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| MENINGOCOCCAL (one dose of conjugate *OR* polysaccharide required)  1. Meningococal conjugate (MCV4 preferred;data for revaccination pending; administer simultaneously with Tdap if possible): \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  2. Meningococal polysaccharide (MPSV4 acceptable alternative if conjugate not available).……………………………………………………….\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| HEPATITIS B (Three doses of vaccine *OR* a positive hepatitis B surface antibody *OR* complete attached waiver)  1. Immunization (Hepatitis B) 2. Immunization 3. Hepatitis B surface antibody  Dose#1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (Combined Hepatitis A and B vaccine) Date\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  Dose#2\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ *OR* Dose#1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ *OR* € Immune  Dose#3\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose#2\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ € Not Immune  Dose#3\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (*Please attach lab results*) |
| PART B. *The following immunizations are strongly recommended (NOT REQUIRED) for students residing in campus housing or attending the University on an F1 or J1 Visa:*  HEPATITIS A ………………………………………………….………………………………………………………………. Dose#1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose#2\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| TUBERCULOSIS SCREENING………………………………………………..……………………….. Date Given:\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Date Read: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  (Record actual mm of indurations, transverse diameter; if no indurations, write “0”……….…………………..Results: \_\_\_\_\_ Positive\_\_\_\_\_ Negative\_\_\_\_\_  Chest x-ray (required if tuberculin skin test is positive)……………..………. result: normal\_\_\_\_\_ abnormal\_\_\_\_\_ Date of chest x-ray: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| PNEUMOCOCCAL POLYSACCHARIDE VACCINE (One dose for members of high-risk groups.)……………………………………. \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| INFLUENZA ………………………………………………………………………………………………….\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| VARICELLA (either a history of chicken pox with a positive varicella antibody *OR* two doses of vaccine)  Varicella antibody date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (*Please attach lab results*)…………………………………………….….…………. Results: € Immune € Not Immune  Immunization: ……………….….………………………………………………………………………………………….. Dose#1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose#2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE (HPV) (Three doses of vaccine for female college students 11-26 years of age at 0, 2, and 6 month intervals.)………………………………………………….Dose#1\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose#2\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Dose#3\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ |
| HEALTH CARE PROVIDER (*Please sign and place health care provider address and phone number or stamp below.)*  Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |