

IMMUNIZATION RECORD

Name: _____ Date of Birth: _____ ID: _____

<p>M.M.R.: (Measles, Mumps, Rubella) Two doses required: Dose #1: Month/Year _____ Dose #2: Month/Year _____</p>
<p>Tetanus-Diphtheria-Pertussis: Date of most recent booster dose: Month/Year _____ Type of booster: Td _____ Tdap _____</p>
<p>Polio: Primary series in childhood meets requirement. Indicate which type of vaccine (OPV, IPV) Dose #1: Month/Year _____ Dose #2: Month/Year _____ Dose #3: Month/Year _____</p>
<p>Varicella: Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart meet this requirement. History of chicken pox: Yes _____ No _____ If Yes, when: Month/Year _____ Varicella antibody: Month/Year: _____ Reactive: _____ Non-reactive: _____ Immunization: Dose #1: Month/Year _____ Dose #2: Month/Year _____** **Dose #2 given at least 1 month after first dose, if age 13 years or older.</p>
<p>Hepatitis B: Three doses of vaccine or a positive Hepatitis B surface antibody meets the requirement. Dose #1: Month/Year _____ Dose #2: Month/Year _____ Dose #3: Month/Year _____ Hepatitis B surface antibody: Month/Year: _____ Reactive _____ Non-reactive _____</p>
<p>Meningococcal Quadrivalent (A, C, Y, W-135): Recommendation is one or two doses for all college students – revaccinate every 5 years if increased risk continues. Quadrivalent conjugate (Menactra): Dose 1: Month/Year _____ Dose 2: Month/Year _____</p>
<p>Tuberculosis Screening: (PPD regardless of prior BCG inoculation) PPD (Mantoux) within the past 12 months (Tine or Monovac not acceptable). Result: Negative _____ Positive _____ mm induration (horizontal diameter) _____ Month/Year _____ If PPD positive, chest x-ray required: X-ray result: Normal _____ Abnormal _____ Mo./Yr. _____ INH Prophylaxis Yes _____ No _____ Number of months medication taken _____</p>

Upon completion of this health history form, may we suggest you **make a copy** as we have found students need this information during their stay here at Santa Clara University.

MAIL COMPLETED FORM TO:

Santa Clara University
Cowell Health Center, Building 701
500 El Camino Real
Santa Clara, CA 95053