

Immunization Record University of New Hampshire

Immunization Requirements: The University of New Hampshire requires verification of immunizations for measles, mumps, rubella. Exact dates are required for all immunizations and/or serological test results.

Please have health care provider complete immunization record.

Student Name _____ SSN# _____ Date of Birth _____
Please Print

Required for all students

Measles, Mumps, and Rubella (MMR)
Month/Day/Year _____ / _____ / _____
_____ / _____ / _____
Recent titers to verify status of protection are required for students who are unable to provide documentation of MMR immunization. Enclose a copy of lab titer results.

Recommended for all students

Tetanus/Diphtheria	Month/Day/Year
Primary series completed DPT/Dtap	_____ / _____ / _____
Booster after 12/1/86 TD/Tdap	_____ / _____ / _____
Hepatitis B vaccine	
1) _____ / _____ / _____	2) _____ / _____ / _____
3) _____ / _____ / _____	
HPV Vaccine (Gardasil)	
1) _____ / _____ / _____	2) _____ / _____ / _____
3) _____ / _____ / _____	

Recommended for all students

Polio	<input type="checkbox"/> Oral (OPV)	<input type="checkbox"/> Salk (IPV)
Primary series of 3 completed	_____ / _____ / _____	
Most recent booster	_____ / _____ / _____	
Other Immunizations		
Meningococcal vaccine	_____ / _____ / _____	
Date of Varivax (Chickenpox vaccine)	_____ / _____ / _____	
Date of Illness (Chickenpox)	_____ / _____ / _____	
Other:	_____ / _____ / _____	

Required only if at high-risk – see Tuberculosis Risk Questions located in the on-line Health History Form

Tuberculin Test	<i>Tine not accepted</i>
*PPD not required unless person is at high risk.	
*Mantoux/PPD	_____ / _____ / _____
Results:	Date Read _____ / _____ / _____
<input type="checkbox"/> Negative	
<input type="checkbox"/> Positive: Chest X-ray required if positive	
Size of induration _____	Must be recorded
Chest X-ray date _____ / _____ / _____	Results _____
Treatment type _____	Duration _____

Immunization Certification (signature required)

Clinician: Review the dates under immunization record for compliance with standards. This form must be signed by a physician, nurse, or public health official.

- If the information above is incomplete, please comment: _____
- _____
- The physical condition of the above named patient is such that immunization would endanger life or health because: _____
- _____
- _____

Clinician's signature _____ Date: _____
Print Name _____ Telephone (_____) _____
Address _____

Return this form to the student when it is complete.