



**UNIVERSITY OF NEW HAMPSHIRE
IMMUNIZATION RECORD**

The University of New Hampshire requires verification of immunizations and/or serological test for Measles, Mumps, and Rubella. Exact dates are required. This form is to be completed by a health care provider. *Please return this form to the student when it is completed. Thank you.*

Student Name: _____ UNH ID# _____ Date of Birth _____

Vaccines	Dates Given	New Hampshire Requirements/Recommendations
MMR	#1 ___/___/___ #2 ___/___/___	This is required by the University; if documentation is not received by the deadline an academic hold may be implemented. 2 doses of MMR (Measles, Mumps, Rubella) or positive titers or 2 doses Measles, 2 doses Mumps, and 1 dose Rubella MMR#1 must be given after 1 st birthday
OR		
Measles	#1 ___/___/___ #2 ___/___/___ Titer date ___/___/___	
Mumps	#1 ___/___/___ #2 ___/___/___ Titer date ___/___/___	
Rubella	#1 ___/___/___ Titer date ___/___/___	
Tdap/Td	Tdap ___/___/___ Td ___/___/___	Tdap/Td booster within the last 10 years
Meningococcal	Date ___/___/___	Recommended for all 1 st year students living in dorms
Varicella (Chicken Pox)	History of illness: date ___/___/___ OR Immunizations: #1 ___/___/___ #2 ___/___/___ OR Titer date ___/___/___	2 doses of Varicella vaccine, minimum of 4 weeks between doses OR Positive Titer
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Titer date ___/___/___	3 doses OR Positive Surface Antibody Titer
DTP/DTaP Series	Series completion date ___/___/___	
Polio Series OPV/IPV	Series completion date ___/___/___	
HPV Series	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___	
TST (Tuberculin Skin Test) Mantoux Method	Date administered ___/___/___ Date read: ___/___/___ Results: ___ mm Chest x-ray date: ___/___/___	Required only if at high risk – see Tuberculosis Risk Questions located online Health History Form Results must be recorded in the exact measurement of induration. Include copy of chest x-ray report. If positive please provide detailed treatment plan.
History of BCG	Date ___/___/___	
OTHER	Vaccine: _____ Date: ___/___/___ Vaccine: _____ Date: ___/___/___ Vaccine: _____ Date: ___/___/___	

The above named patient is requesting exemption from the immunizations requirements/recommendations. Please provide proper documentation supporting the exemption(s). Health Religious Other

Health care provider's _____
 (Signature) (Print name) (Date)

Address: _____ Telephone: (____) _____