

IMMUNIZATION VERIFICATION - Required for University of New Hampshire attendance

To avoid delay in registration, please complete and return this form by July 1st for Fall Registration and January 1st for Spring Registration.

Name (printed): _____ Date of Birth: _____

Home Address: _____ Home Telephone: _____

City State Zip Social Security Number: _____

THIS SECTION TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

Month / Day / Year

A. MMR (MEASLES, MUMPS, RUBELLA) – 2 doses required (1ST dose on or after first birthday)

__ Dose 1 - include month, day, and year
__ Dose 2 - include month, day, and year

B. MEASLES (RUBEOLA) – If given instead of MMR. 2 doses required on or after first birthday.

__ Born before 1957 and therefore considered immune.
__ Dose 1 - include month, day, and year
__ Dose 2 - include month, day, and year
__ Has report of positive immune titer. Specify date of titer
__ Had disease: confirmed by office record

C. MUMPS – If given instead of MMR.

__ Born before 1957 and therefore considered immune
__ Had disease: confirmed by office record
__ Immunized with vaccine at 12 months of age or later
__ Has report of positive immune titer. Specify date of titer

D. RUBELLA – If given instead of MMR.

A clinical diagnosis of rubella is not acceptable proof of immunity.
__ Immunized with vaccine at 12 months of age or later
__ Has report of positive immune titer. Specify date of titer

E. TETANUS-DIPHTHERIA

__ Completed primary series of tetanus-diphtheria immunizations
__ Date of most recent tetanus-diphtheria booster

F. TUBERCULOSIS

__ PPD test/Mantoux
__ Test results: Positive: [] Negative: []

G. POLIO

__ Completed primary series of polio immunization
Type of vaccine __ Oral __ Inactivated __ E-IPV
Last booster

H. HEPATITIS B

__ Dose 1 - include month, day, and year
__ Dose 2 - include month, day, and year
__ Dose 3 - include month, day, and year
__ Has report of positive immune titer. Specify date of titer

I. MENINGOCOCCAL

__ Dose - include month, day, and year

Please return to:
University of New Hampshire
Medical Records Department
12 Ballard Street
Durham, NH 03824
Phone: 603-862-1530
FAX: 603-862-4259

File: MR001.pm5
Date of Revision: 01Apr2001

HEALTH CARE PROVIDER INFORMATION:

Printed Name: _____
Address: _____
Phone: _____
Signature: _____
Date: _____