



The university requires verification of immunizations and/or serological test for Measles, Mumps, and Rubella (exact dates required). If documentation is not received by the deadline, an academic hold may be implemented. This form is to be completed by a health care clinician.

Student Name: _____ Preferred Name: _____ Date of Birth: _____

Vaccines	Dates Given	NH Requirements & Recommendations
MMR	#1: ___/___/___ #2: ___/___/___	2 doses for MMR (Measles, Mumps, Rubella), with first dose given after 1st birthday; positive titers (include copy of lab work); or 2 doses Measles, 2 doses Mumps and 1 dose Rubella
OR		
Measles	#1: ___/___/___ #2: ___/___/___ Titer: ___/___/___	
Mumps	#1: ___/___/___ #2: ___/___/___ Titer: ___/___/___	
Rubella	#1: ___/___/___ Titer: ___/___/___	
Tdap/Td	Tdap: ___/___/___ Td: ___/___/___	Tdap/Td booster within the last 10 years
Meningococcal ACWY	#1: ___/___/___ #2: ___/___/___	Meningococcal ACWY is recommended for all 1st year students living in residence halls. Talk with your clinician about these vaccinations.
Meningococcal B	#1: ___/___/___ #2: ___/___/___ #3: ___/___/___	
Varicella (chicken pox)	#1: ___/___/___ #2: ___/___/___ OR Illness: ___/___/___ OR Titer: ___/___/___	History of illness, 2 doses of Varicella vaccine (minimum of 4 weeks between doses), or positive titer
Hepatitis B	#1: ___/___/___ #2: ___/___/___ #3: ___/___/___ OR Titer: ___/___/___	3 doses OR positive surface antibody titer
DTP/DTaP Series	Series completion: ___/___/___	
Polio Series (OPV/IPV)	Series completion: ___/___/___	
HPV Series	#1: ___/___/___ #2: ___/___/___ #3: ___/___/___	
TST (Tuberculin Skin Test) Mantoux Method	Date administered: ___/___/___ Results: ___ mm Date read: ___/___/___ Chest x-ray date: ___/___/___ Include a copy of the chest x-ray.	Required only if at high risk. Students must complete the Tuberculosis Screening at unh.edu/health-services/incoming-students to determine risk.
History of BCG	Date: ___/___/___	
Other Vaccines	Date: ___/___/___ Date: ___/___/___ 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 clinician _____
(Signature) (Print name) (Date)

Address: _____ Telephone: (____) _____