University of New Hampshire

Health Services Immunization Record Form

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: (_____)**________________

The Health Services Immunization Record Form must be completed by a physician or a nurse practitioner/physician's assistant. The student should upload the completed form online at www.unh.edu/health-services/incoming-students.