

Cornerstone University Health Services

IMMUNIZATION HISTORY

(Please print) Last Name, First, Middle Initial	Date of birth	Cornerstone ID #
---	---------------	------------------

The following vaccinations are **required for admittance** to Cornerstone University. You should receive any vaccines at your primary care provider **prior to coming to Cornerstone**.

Please note: If you are unable to locate your immunization records, you will be **required** to either restart vaccinations or show documented proof of immunity by laboratory testing. These vaccinations are also a requirement for future travel with a Cornerstone University off-campus program.

1. TETANUS-DIPHTHERIA and PERTUSSIS

Primary series with Diphtheria, Pertussis and Tetanus (DTP) or Diphtheria and Tetanus (TD or DT) and a booster within the past ten years **required**.

DIPHTHERIA, PERTUSSIS, TETANUS or DIPHTHERIA, TETANUS	#1 MM / DD /YY	#2 MM / DD /YY	#3 MM / DD /YY	#4 MM / DD /YY	#5 MM / DD /YY	Td MM / DD /YY	Tdap* MM / DD /YY
---	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	-----------------------	--------------------------

*Consider Tdap booster if last Tetanus shot was a Td.

2. POLIO

OPV (oral)	#1 MM / DD /YY	#2 MM / DD /YY	#3 MM / DD /YY	#4 MM / DD /YY	#5 MM / DD /YY
OR					
IPV (injected)	#1 MM / DD /YY	#2 MM / DD /YY	#3 MM / DD /YY	#4 MM / DD /YY	#5 MM / DD /YY

3. MENINGOCOCCAL QUADRIVALENT (vaccine must cover strains A, C, Y, W-135)

Please note: Two doses of MCV4 are recommended for adolescents 11 through 18 years of age: first dose at 11 or 12 years of age, with a booster dose at age 16. If the first dose is given between 13 and 15 years of age, the booster should be given between 16 and 18.

If first dose is given after the 16th birthday, a booster is not needed. If never vaccinated before, one dose is **required** prior to college. No dose is necessary if age 22 or older.

Polysaccharide MPSV4	MM / DD /YY	MM / DD /YY	OR	Conjugate (MCV4) Menactra/Menveo	MM / DD /YY	MM / DD /YY
-------------------------	-------------	-------------	-----------	-------------------------------------	-------------	-------------

4. HEPATITIS B

Three doses of vaccine **OR** a positive Hepatitis surface antibody **OR** two-shot Hepatitis B series (Merck Recombivax HB) given between ages 11 and 15.

HEPATITIS B IMMUNIZATION (x3) OR HEP B MERCK RECOMBIVAX HB (x2)	#1 MM / DD /YY	#2 MM / DD /YY	#3 MM / DD /YY	OR	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 30%; padding: 5px;">HEP B TITER</td> <td style="width: 70%; padding: 5px;"> Result (include copy of lab report): _____ Reactive/Immune _____ Non-reactive/not immune </td> </tr> <tr> <td colspan="2" style="padding: 5px;"> Optional Labs: Hep B Surface Antigen Date: _____ _____ Reactive _____ Non-Reactive Hep B Core Date: _____ _____ Reactive _____ Non-Reactive </td> </tr> </table>	HEP B TITER	Result (include copy of lab report): _____ Reactive/Immune _____ Non-reactive/not immune	Optional Labs: Hep B Surface Antigen Date: _____ _____ Reactive _____ Non-Reactive Hep B Core Date: _____ _____ Reactive _____ Non-Reactive	
HEP B TITER	Result (include copy of lab report): _____ Reactive/Immune _____ Non-reactive/not immune								
Optional Labs: Hep B Surface Antigen Date: _____ _____ Reactive _____ Non-Reactive Hep B Core Date: _____ _____ Reactive _____ Non-Reactive									
#1 MM / DD /YY	#2 MM / DD /YY								

5. VARICELLA

Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least 12 weeks apart if given between 1 and 12 years of age or 28 days apart if given at 13 years of age or older is **required**.

VARICELLA IMMUNIZATIONS OR VARICELLA TITERS	#1 MM / DD / YY	#2 MM / DD / YY	OR	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td colspan="2" style="padding: 5px;">HISTORY OF DISEASE</td> </tr> <tr> <td style="width: 30%; padding: 5px;">YES _____</td> <td style="padding: 5px;">Date (if known): _____ MM / DD /YY</td> </tr> <tr> <td colspan="2" style="padding: 5px;">NO _____</td> </tr> </table>	HISTORY OF DISEASE		YES _____	Date (if known): _____ MM / DD /YY	NO _____	
HISTORY OF DISEASE										
YES _____	Date (if known): _____ MM / DD /YY									
NO _____										
#1 MM / DD / YY										
	#2 MM / DD / YY	Result (include copy of lab report): _____ Reactive/Immune _____ Non-reactive/not immune								

(continued)

(Please print) Last Name, First, Middle Initial	Date of birth	Cornerstone ID #
---	---------------	------------------

6. TUBERCULOSIS:

If you answered **YES** to any questions on the TB Self-Screening form, a TB Skin Test is required. **Please note:** A BCG vaccination does not exempt you from the need to receive a TB Skin Test if you answered yes to any questions on the self-screening form.

Tuberculin Skin Test Date Given: ____/____/____ Date Read: ____/____/____ Result: ____ mm <small>(record actual mm of induration; if no induration, write "0")</small>
Chest X-ray (Required if PPD is 10mm or greater. Please submit a copy of the x-ray report.) Date Given: ____/____/____ Result: _____ (normal/abnormal)
Blood Tests for TB T-Spot® TB: Date Given: ____/____/____ Result: _____ (include copy of lab report) QuantiFERON® TB Gold: Date Given: ____/____/____ Result: _____ (include copy of lab report)

7. M.M.R. (Measles, Mumps, Rubella)

Two doses of M.M.R. are **required**. Dose #1 given after first birthday. Dose #2 given at least 4 weeks after initial dose.

M.M.R. (MEASLES, MUMPS, RUBELLA)	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY
--	--	--

OR

MEASLES TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): ____ Reactive/Immune ____ Non-reactive/not immune
MUMPS TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): ____ Reactive/Immune ____ Non-reactive/not immune
RUBELLA TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): ____ Reactive/Immune ____ Non-reactive/not immune

8. OTHER IMMUNIZATIONS RECEIVED

i.e. HPV (recommended for males and females 11-26 years old), Hepatitis A (recommended for adolescents through age 18), Typhoid, Yellow Fever, Twinrix, etc.

	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY
	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY
	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY

Please have this form completed and signed by a health care professional, **or** submit an official photocopy of your immunization records, and fax or mail **directly to Health Services**. (see address and fax below)

REQUIRED HEALTH CARE PROFESSIONAL'S SIGNATURE (Physician, Nurse, Health Dept. Stamp – not immediate family member): Print name _____ Address _____ Signature _____ Date ____/____/____ Phone () _____
