VADEN HEALTH CENTER STANFORD

Stanford University Immunization Form for Non-Medical Students
FAX TO 650-498-1118

Last Name: Koratang First Name: Animesh Middle Initial: R

Date of Birth: 04 / 12 / 1999 SU ID Number (if known): 06175223

DO NOT SEND IMMUNIZATION RECORDS; USE THIS FORM ONLY

REQUIRED IMMUNIZATIONS

MMR 2 doses required or individual vaccines as listed below	Date #1: (Given on or after 12 months of age) 05/05/00		Date #2: (Given 28 days or more after #1 dose) 05/29/03
Measles (Rubeola) 2 doses required for all students born after 1956	Date #1: 05/05/00	Date #2: 05/29/03	OR Laboratory Evidence of Immunity *Include Report* *(Revaccinate for Equivocal Titer)*
Mumps 2 doses required for all students regardless of age	Date #1: 05/03/00	Date #2: 05/29/03	OR Laboratory Evidence of Immunity *Include Report* *(Revaccinate for Equivocal Titer)*
Rubella (German Measles) 1 dose required for all students regardless of age	Date #1: 05/03/00		OR Laboratory Evidence of Immunity *Include Report* *(Revaccinate for Equivocal Titer)*

HIGHLY RECOMMENDED IMMUNIZATIONS

Hepatitis B 3 doses required	Date #1: 05/01/99	Date #2: 05/29/99	Date #3: 11/09/99	OR Laboratory Evidence of Immunity *Include Report* *(Revaccinate for Equivocal Titer)*
Or, if History of Hepatitis B Disease: **Must include report for Hepatitis Core Antibody, Hepatitis Surface Antibody & Hepatitis Surface Antigen titers**				
Tetanus-Diphtheria-Pertussis Vaccine must be **Tdap** regardless of last Td vaccine	Booster must be within the past 10 years	**Tdap** Date: 08/12/10		
Varicella (Chicken Pox) 2 doses required	Date # 1: 08/22/00	Date #2: 05/03/07	OR Laboratory Evidence of Immunity *Include Report* *(Revaccinate for Equivocal Titer)*	

Meningococcal Vaccine	List Type of Vaccine:		Date:
HPV (List Type and Date)	Date #1:	Date #2:	Date #3:
Hepatitis A	Date #1: 05/19/06		Date #2: 05/03/07
Pneumococcal Vaccine if indicated (*)	(*) History of asthma, other lung diseases, immune issue, smoker. **List type of Vaccine:**		Date:

ADDITIONAL IMMUNIZATION HISTORY

Japanese Encephalitis	Date #1:		Date #2:	Date #3:	
Rabies	Date #1:	Date #2:	Date #3:	Date #4:	
Typhoid ☑ **Injectable** ☐ **Oral**	Date: 05/16/2011				
Yellow Fever	Date:				
Primary Polio Series	Date #1: 05/[illegible]/1999	Date #2: 05/29/1999 [illegible]		Date #3: 11/14/2000	Date #4: 05/29/2003
Adult Polio Booster	Date:				
Primary Tetanus (DTaP) Series	Date #1: 07/16/99	Date #2: 09/07/99	Date #3 11/09/00	Date #4 11/14/00	Date #5 05/29/03

Signature of Health Provider: _____ Date: _____

***Signing Provider is verifying all dates above are accurate**

Physician / Medical Provider Name: (Please Print) / Clinic Stamp: _____

Address: PANDYA MEDICAL CENTER
3925-A Johns Creek Court
Suwanee, GA 30024

Phone number: Phone: 770-709-6922 Fax Number: Fax: 770-709-6910

5.2014