Dartmouth College Health Service at Dick's House

7 Rope Ferry Road, Hanover, NH 03755 P: (603) 646-9405

DUE DATE: June 30, 2025

Immunization Form for Undergraduate Students

FIRST NAME	MI	LAST NAME	BIRTHDATE (MM/DD/YY)

CONTACT EMAIL _____ CONTACT PHONE NUMBER _____

REQUIRED IMMUNIZATIONS

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
Tetanus, Diphtheria, Pertussis Primary Series (DTap, DTP, or DT) 4-5 shot series received in early childhood.	/ /	/ /	/ /	/ / **If applicable date #5:** / /
Tdap Booster: Dartmouth requires a Tdap on/after age 11. A valid Tdap shot dated after 9/1/15 is also required. If Tdap was given after age 11 and after 9/1/15 it will meet both requirements.	**International Student: Tdap not available in home country. Vaccine will be received at Dartmouth College ( ).**	/ / **Tdap (Required)**	/ / **dT (If booster is something other than dT, please specify below)** _____	
MMR Vaccine Two doses required *(doses must be given at least 28 days apart beginning on or after 12 months of age)*	/ /	/ /	**The MMR vaccines may be substituted with 2 Measles, 2 Mumps and 1 Rubella vaccine, medically documented proof of disease OR laboratory evidence of immunity.**	
MEASLES	/ /	/ /	**( ) Titer Must Attach Report**	
MUMPS	/ /	/ /	**( )Titer Must Attach Report**	
RUBELLA	/ /	**( ) Titer Must Attach Report**		

POLIO PRIMARY SERIES (OPV or IPV) 4-5 shots received in early childhood. IMPORTANT! If polio vaccine has never been administered, please start the IPV series. Three doses of IPV are REQUIRED	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )
VARICELLA Provider-documented disease, two vaccine doses, or positive titer. *(doses must be given at least 28 days apart beginning on or after 12 months of age).*	/ /	/ /	**Verified Date of Disease** / /	**( ) Positive Titer- Must *Attach Report***
Hepatitis B (3 DOSE vaccines OR positive titer REQUIRED) *2 dose series (Heplisav) allowed if over 18. *	/ / / /	/ / / /	/ / **Specify 2- or 3- Dose Series + Vaccine Name**	**( ) Positive Titer- Must Attach Report**
QUADRIVALENT MENINGOCOCCAL CONJUGATE ACYW-135: If the initial dose is before age 16, a booster at 16 or older is REQUIRED, even after 2+ doses. If initial dose administered at age 16 or older, booster dose is not required.	**Indicate Type:** _____ / /	/ /		

RECOMMENDED VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
Most Recent COVID Booster	/ /		**Manufacturer:**	
Hepatitis A	/ /	/ /		
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Meningococcal B	/ /	/ /		
Most Recent Influenza	/ /			

OTHER VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
BCG	/ /			
Typhoid Oral ( ) IM ( )	/ /	/ /		
Pneumococcal PCV 13( ) PCV 15 ( ) PPSV23 ( )	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Yellow Fever	/ /			
Japanese Encephalitis	/ /	/ /	/ /	
Jynneos (Orthopox Virus)	/ /	/ /		
Haemophilus Influenza Type B	/ /	/ /	/ /	/ /
Herpes Zoster	/ /	/ /		
PLEASE WRITE IN ANY ADDITIONAL UNLISTED VACCINATIONS BELOW				
Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

Health care provider signature/stamp (REQUIRED):

_____**(MD / DO / PA / APRN / RN / LPN)** _____
SIGNATURE OF HEALTH CARE PROVIDER DATE

provider/facility stamp here

_____ _____
PRINTED/TYPED NAME OF HEALTH CARE PROVIDER TELEPHONE NUMBER

Instructions:

Health care provider:

1. Please complete this form ensuring patient is in compliance with all 'REQUIRED IMMUNIZATIONS'.
2. Please sign and date the form (above).
3. Please provide patient with the original or a copy of the completed form.
4. In lieu of this form an official signed copy of your immunization records (translated in English) will suffice the requirement.

Student:

1 Please use your copy of this form or immunization records to enter vaccine dates into the ONLINE Immunization Form located on our direct web link: https:\\healthservices.dartmouth.edu

2. Upload your immunization record or a completed copy of this form to the ONLINE student health portal. For questions please email: Medical.records.for.student.health@dartmouth.edu

3. **Both steps #1 and #2 are REQUIRED. You must enter immunization dates Online and upload a copy of this form or a copy of your immunization records to the student health web portal under the Immunization Forms Category.**

DO NOT MAIL OR EMAIL ANY DOCUMENTS