

**THIS FORM IS REQUIRED AND WILL BE READ ELECTRONICALLY. DATES MUST BE ENTERED ON THIS FORM.  
DO NOT ATTACH A SEPARATE VACCINATION RECORD. All dates must in MM-DD-YYYY format.**

### Part 1: Required for all Students

**1. MEASLES, MUMPS, RUBELLA (MMR) IMMUNITY – \* ± Required for all students**

**2. VARICELLA IMMUNITY – \* ± Required for all students born after 1979**

**3. MENINGOCOCCAL Vaccination – \* ± Required of all undergraduate and graduate students living in university dormitories**

Page 1 of 3



**Part 2: Required for all Health Professions Students****4. TUBERCULOSIS (TB) – ± Required for Health Professions Students – All other students to complete TB Risk Assessment Form (in packet)**

|  |  |   |                           |   |  |
|--|--|---|---------------------------|---|--|
| <b>STEP 1: TB Blood Test/IGRA</b>  |  | <b>OR</b>   | <b>TB Skin Test (PPD)</b> | <b>STEP 2: DO NOT COMPLETE UNLESS POSITIVE TB SKIN TEST OR TB BLOOD TEST</b>  |  |
| <input checked="" type="checkbox"/> QuantiFERON <input checked="" type="checkbox"/> T-Spot<br>Date: <u>01-01-2023</u><br>MM DD YYYY<br>RESULT: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS*<br>Required: <input checked="" type="checkbox"/> Attach lab results. |  | Date planted: <u>06-15-2023</u><br>MM DD YYYY<br>Date read: <u>06-30-2023</u><br>MM DD YYYY<br>Interpretation: <input checked="" type="checkbox"/> NEG <input checked="" type="checkbox"/> POS*<br>mm of induration: <u>9</u> |                           | <b>CHEST XRAY</b><br>Required if past or current positive TB skin or blood test. Not required if completed medication treatment for TB.<br>Chest X-ray Date: <u>01-01-2024</u><br>MM DD YYYY<br><input checked="" type="checkbox"/> Normal <input checked="" type="checkbox"/> Abnormal |  |
|  |  |   |                           | <b>TB TREATMENT</b><br><input checked="" type="checkbox"/> Latent TB Infection<br><input checked="" type="checkbox"/> Active TB Infection<br>Date(s): <u>06-30-2023</u><br>MM DD YYYY<br>List Medication(s):<br><u>None</u>   |  |

**5. COVID-19 VACCINATION – ± Required for Health Professions Students – Strongly encouraged for all other students.**  
 • Please submit documentation of prior vaccine doses **AND at least one (1) dose of 2023-2024 updated formulation.**

|  |   |  |
|--|---|--|
| <b>PRIMARY DOSE #1</b>   | <b>PRIMARY DOSE #2 (skip if J&amp;J vaccine)</b>  | <b>COVID-19 updated 2023-2024 dose</b>   |
| Date: <u>03-15-2021</u><br>MM DD YYYY<br><input checked="" type="checkbox"/> Moderna<br><input checked="" type="checkbox"/> Pfizer<br><input checked="" type="checkbox"/> Johnson & Johnson/Janssen<br><input checked="" type="checkbox"/> Novavax<br><input checked="" type="checkbox"/> Other WHO approved<br>Name: <u>Bob</u> | Date: <u>04-15-2021</u><br>MM DD YYYY<br><input checked="" type="checkbox"/> Moderna<br><input checked="" type="checkbox"/> Pfizer<br><input checked="" type="checkbox"/> Novavax<br><input checked="" type="checkbox"/> Other WHO approved<br>Name: <u>Sam</u> | Date: <u>10-13-2023</u><br>MM DD YYYY<br><input checked="" type="checkbox"/> Moderna<br><input checked="" type="checkbox"/> Pfizer<br><input checked="" type="checkbox"/> Novavax<br>Name: <u>Test</u> |

**6. Hepatitis B Immunity – ± Required for Health Professions Students – Not required for all other students.**  
 Documentation of a COMPLETE series of Hepatitis B vaccination AND quantitative antibody titer.

|   |                                 |                                 |   |  |
|---|---------------------------------|---------------------------------|---|--|
| <b>Hepatitis B Vaccine (enter name)</b> | <b>Date of Dose #1:</b>         | <b>Date of Dose #2:</b>         | <b>Date of Dose #3 (if applicable):</b> | <b>Hep B Surface Antibody Titer (QUANTITATIVE)</b>   |
|   | <u>01-01-2022</u><br>MM DD YYYY | <u>03-01-2022</u><br>MM DD YYYY | <u>05-01-2022</u><br>MM DD YYYY         | <u>06-01-2023</u><br>MM DD YYYY  |
|   |                                 |                                 |   | Result: <u>12</u> IU / sc<br><input checked="" type="checkbox"/> Immune <input checked="" type="checkbox"/> Not Immune |

**7. TETANUS-DIPHTHERIA-PERTUSSIS (Tdap) – ± Required for Health Professions Students – Not required for all other students.**

|   |                                       |
|---|---------------------------------------|
| <b>Only Tdap is accepted within the past 10 years</b> | <b>Date of most recent Tdap dose:</b> |
|   | <u>02-10-2024</u><br>MM DD YYYY       |

**8. INFLUENZA VACCINATION: ± Required for Health Professions Students, documentation to be submitted during flu season. Recommended but not required for all other students.**

|  |                                       |
|--|---------------------------------------|
| <b>Influenza (Flu) Vaccination</b>                           | <b>Date of Influenza Vaccination:</b> |
|  | <u>10-13-2023</u><br>MM DD YYYY       |
| Must be between September and March of CURRENT academic year |                                       |

**Part 3: Recommended vaccines based on personal history – (please record if applicable)****OTHER VACCINES - NOT required**

|  |   |   |   |  |
|--|---|---|---|--|
| <b>Hepatitis A Vaccine</b>               | Date of Dose #1:<br><u>01-01-2006</u><br>MM DD YYYY   | Date of Dose #2:<br><u>03-01-2006</u><br>MM DD YYYY |   |  |
| <b>HPV Vaccine</b>                       | <input checked="" type="checkbox"/> HPV 4<br><input checked="" type="checkbox"/> HPV 9                        | Date of Dose #1:<br><u>01-01-2004</u><br>MM DD YYYY | Date of Dose #2:<br><u>03-01-2004</u><br>MM DD YYYY | Date of Dose #3:<br><u>05-01-2004</u><br>MM DD YYYY            |
| <b>Meningococcal Serogroup B Vaccine</b> | <input checked="" type="checkbox"/> Bexsero, 2 doses<br><input checked="" type="checkbox"/> Trumenba, 3 doses | Date of Dose #1:<br><u>01-01-2004</u><br>MM DD YYYY | Date of Dose #2:<br><u>03-01-2004</u><br>MM DD YYYY | Date of Dose #3 (if Trumenba): <u>05-01-2004</u><br>MM DD YYYY |
| <b>Yellow Fever</b>                      | <input checked="" type="checkbox"/> Yellow Fever<br><input checked="" type="checkbox"/> Stamaril              | Date of Dose:<br><u>06-01-2010</u><br>MM DD YYYY    |   |  |
| <b>Typhoid</b>                           | Date of Dose:<br><u>06-01-2010</u><br>MM DD YYYY  |   |   |  |

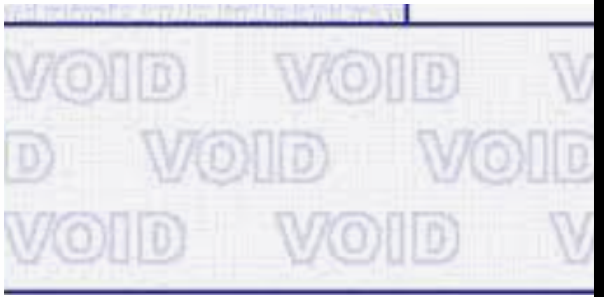
**Part 4: Medical Provider Certification of the Above Information**

|  |                                   |  |
|--|-----------------------------------|--|
| <b>Medical Provider Name</b><br><u>Dr Rubenstein</u>                         | <b>Medical Provider Signature</b> | <b>Date</b><br><u>02-20-2024</u><br>Month Day Year |
| <b>Address (Include city and state)</b><br><u>5 Peguot Pl. Westbrook, CT</u> |                                   | <b>Telephone</b><br><u>203 555 1212</u>            |
| <b>State or Country of Licensure / License #</b><br><u>CT 1234567</u>        |                                   | <b>Fax</b><br><u>203 555 1213</u>                  |

Form must be stamped or Signed by Medical Provider

Stamp

Signature

|   |  |
|---|--|
|  |  |
|---|--|