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**.

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

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

2. POLIO

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

	#1	#2	#3
HEPATITIS B IMMUNIZATION (x3)	_____ MM / DD /YY	_____ MM / DD /YY	_____ MM / DD /YY
OR			
HEP B MERCK RECOMBIVAX HB (x2)	_____ MM / DD /YY	_____ MM / DD /YY	

OR

HEP B TITER	**Result (include copy of lab report):**
_____ MM / DD /YY	_____Reactive/Immune _____Non-reactive/not immune
Optional Labs: Hep B Surface Antigen Date:_____ _____Reactive _____Non-Reactive Hep B Core Date:_____ _____Reactive _____Non-Reactive	

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**.

	#1	#2
VARICELLA IMMUNIZATIONS	_____ MM / DD / YY	_____ MM / DD / YY
OR		
VARICELLA TITERS	_____ MM / DD / YY	**Result (include copy of lab report):** _____Reactive/Immune _____Non-reactive/not immune

OR

HISTORY OF DISEASE

YES _____ Date (if known): _____ MM / DD /YY

NO _____

(continued)

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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
(record actual mm of induration; if no induration, write "0")

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**	**#2**
	MM / DD / YYYY	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 ( ) ____________________________

Cornerstone Health Services 1001 E. Beltline Ave. NE Grand Rapids, MI 49525

Phone: (616) 222-1441 Fax: (616) 222-1541 E-mail: health.services@cornerstone.edu **Web**. http://www.cornerstone.edu/campus-health-services