

# Cornerstone University Health Services

## IMMUNIZATION HISTORY

(Please print) Last Name, First, Middle Initial	Date of birth	Cornerstone ID #
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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
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\*Consider Tdap booster if last Tetanus shot was a Td.

### 2. POLIO

OPV (oral)  <b>OR</b>  IPV (injected)	#1 _____ MM / DD / YY	#2 _____ MM / DD / YY	#3 _____ MM / DD / YY	#4 _____ MM / DD / YY	#5 _____ MM / DD / YY
	#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 16<sup>th</sup> 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	<b>OR</b>	Conjugate (MCV4) Menactra/Menveo _____ MM / DD / YY	_____ MM / DD / YY
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### 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.

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">HEPATITIS B IMMUNIZATION (x3)  <b>OR</b>  HEP B MERCK RECOMBIVAX HB (x2)</td> <td style="width: 12.5%; padding: 5px;">#1 _____ MM / DD / YY</td> <td style="width: 12.5%; padding: 5px;">#2 _____ MM / DD / YY</td> <td style="width: 12.5%; padding: 5px;">#3 _____ MM / DD / YY</td> </tr> <tr> <td></td> <td style="padding: 5px;">#1 _____ MM / DD / YY</td> <td style="padding: 5px;">#2 _____ MM / DD / YY</td> <td></td> </tr> </table>	HEPATITIS B IMMUNIZATION (x3)  <b>OR</b>  HEP B MERCK RECOMBIVAX HB (x2)	#1 _____ MM / DD / YY	#2 _____ MM / DD / YY	#3 _____ MM / DD / YY		#1 _____ MM / DD / YY	#2 _____ MM / DD / YY		<b>OR</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 25%; padding: 5px;">HEP B TITER _____ MM / DD / YY</td> <td style="width: 75%; padding: 5px;"><b>Result (include copy of lab report):</b> ____ Reactive/Immune ____ Non-reactive/not immune</td> </tr> <tr> <td colspan="2" style="padding: 5px;"><b>Optional Labs:</b></td> </tr> <tr> <td colspan="2" style="padding: 5px;">Hep B Surface Antigen</td> </tr> <tr> <td style="padding: 5px;">Date: _____</td> <td style="padding: 5px;">____ Reactive ____ Non-Reactive</td> </tr> <tr> <td colspan="2" style="padding: 5px;">Hep B Core</td> </tr> <tr> <td style="padding: 5px;">Date: _____</td> <td style="padding: 5px;">____ Reactive ____ Non-Reactive</td> </tr> </table>	HEP B TITER _____ MM / DD / YY	<b>Result (include copy of lab report):</b> ____ Reactive/Immune ____ Non-reactive/not immune	<b>Optional Labs:</b>		Hep B Surface Antigen		Date: _____	____ Reactive ____ Non-Reactive	Hep B Core		Date: _____	____ Reactive ____ Non-Reactive
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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.**

<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 15%; padding: 5px;">VARICELLA IMMUNIZATIONS  <b>OR</b>  VARICELLA TITERS</td> <td style="width: 12.5%; padding: 5px;">#1 _____ MM / DD / YY</td> <td style="width: 12.5%; padding: 5px;">#2 _____ MM / DD / YY</td> </tr> <tr> <td></td> <td style="padding: 5px;">_____ MM / DD / YY</td> <td style="padding: 5px;"><b>Result (include copy of lab report):</b> ____ Reactive/Immune ____ Non-reactive/not immune</td> </tr> </table>	VARICELLA IMMUNIZATIONS  <b>OR</b>  VARICELLA TITERS	#1 _____ MM / DD / YY	#2 _____ MM / DD / YY		_____ MM / DD / YY	<b>Result (include copy of lab report):</b> ____ Reactive/Immune ____ Non-reactive/not immune	<b>OR</b>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 100%; padding: 5px;">HISTORY OF DISEASE</td> </tr> <tr> <td style="padding: 5px;">YES _____ Date (if known): _____ MM / DD / YY</td> </tr> <tr> <td style="padding: 5px;">NO _____</td> </tr> </table>	HISTORY OF DISEASE	YES _____ Date (if known): _____ MM / DD / YY	NO _____
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	_____ MM / DD / YY	<b>Result (include copy of lab report):</b> ____ Reactive/Immune ____ Non-reactive/not immune									
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.

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

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

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