VCOM IMMUNIZATION FORM

Directions: Fill in completely and provide supporting medical record documentation, including titer lab reports.

First Name: _____ **Last Name:**_____

Date of birth: (mm/dd/yyyy) _____

Campus: ❑Auburn ❑Carolinas ❑Louisiana ❑Virginia

Class year: (anticipated year of VCOM graduation) _____

≫MEASLES, MUMPS, RUBELLA (MMR)

Vaccination dates: #1: _____ #2: _____

MMR titer (required only if vaccination dates with confirmation unavailable.)

Measles titer Date: _____ ____Immune ____ Non-Immune

Mumps titer Date: _____ ____Immune ____ Non-Immune

Rubella titer Date: _____ ____Immune ____ Non-Immune

Must have documentation or physician signature attesting to vaccinations. If not available, must have titer done.

≫COVID-19 One dose of Johnson & Johnson or 2 doses of Moderna or Pfizer

Dose #1 Date_____ Dose #2 Date_____ Dose #3 Date_____ Type: (Circle type.) J&J Moderna Pfizer

≫ HEPATITIS

> Hepatitis B immunity

Vaccination dates and also titer showing current level of immunity (HBsAb) required. Vaccination series can be either a series of 3 single-antigen vaccines (injections given at 0, 1, and 6 months) or 2 combination vaccines.

Vaccination dates: #1: _____ #2 _____ #3 _____

Surface Antibody (HBsAb) Titer: Date: _____ Results: ____Immune ____ Non-Immune*

**revaccination& re-titer required*

Include copy of titer lab results.

> Hepatitis C testing

Anti HCV Titer: Date: _____ Results: ____Negative ____ Positive

Include copy of titer lab results.

> Hepatitis A vaccinations (optional) Recommended, but not required.

Vaccination dates: #1: _____ #2 _____

≫DIPHTHERIA, TETANUS, PERTUSSIS

DTP, DT, Td, DTaP dates: #1: _____ #2: _____ #3: _____ #4: _____ #5: _____

Tdap date(s): _____ _____

Td date(s): _____ _____

Vaccination must be current.
Must have Td or Tdap shot every 10 years.

≫VARICELLA (CHICKEN POX)

Vaccination series dates: #1: _____ #2: _____

OR Titer Date: _____

Results: ____Immune ____ Non-Immune

Must provide documentation of either vaccinations or a titer showing immunity and include lab results.

≫OTHER optional vaccination(s):

Recommended, but not required. Also, HIV Testing is recommended, but results do NOT have to be reported to VCOM.

Meningococcal dates: _____ _____ _____ _____

Typhoid date: _____ _____ _____ _____

Yellow fever date: _____

Polio dates: _____ _____ _____ _____ _____

Influenza: *n/a (students receive in fall of first academic year and annually thereafter)*

**Must be signed by healthcare provider (D.O., M.D., P.A., N.P., or Nurse)*

_____ _____ _____

Healthcare Provider Name (print) Signature Date

Practice Name: _____

Practice Address: _____ Phone: _____