NORTH CAROLINA REQUIRED
IMMUNIZATION RECORD & MEDICAL HISTORY FORM

Welcome to Fayetteville State University Student Health Service!!
Student Health Service’s MISSION is to provide quality health care for students enrolled at
Fayetteville State University. Student Health Service (SHS) provides reasonable patient
Healthcare for minor illnesses and injuries. We look forward to serving you.
If you have any questions regarding this form, please call 910-672-1259.

### IMPORTANT !!
DEADLINE JUNE 1st

Return your form by June 1st if you are entering
school for Fall semester. If you are entering
Fayetteville State University for Spring or Summer
sessions, or in case of late acceptance, you must submit
this form within 10 days of your acceptance
notification. Please return any attached copies of
immunization records in the same envelope. All forms
must be sent directly to Student Health Services.

Avoid Registration Cancellations by
Returning this FORM!

All new, transfer, and readmitted FSU students
(who have NOT attended FSU in the past two years)
MUST complete this form.

Include your name and/or FSU Personal ID#
(Banner #) on all attachments.

### FSU Student Insurance Plan

All registered students are required to enroll in this insurance plan
unless proof of comparable coverage is furnished online only at
studentbluenc.com/fsu. Insurance Premium will appear on the
Covered Student’s tuition bill. Online, home study, and television
courses do not fulfill the eligibility requirements.
Information regarding FSU Student Insurance Plan may be ob-
tained by calling 910-672-1259 or 910-672-2121.

### North Carolina
General Statue

North Carolina State Law
(General Statute 130A 152-157) requires that all
students entering college present a certificate of
immunization, which documents that the student has
received the immunizations required by law. Under
this law, REGISTRATION WILL BE CANCE-
CELLED AND THE STUDENT ACADEMI-
CALLY WITHDRAWN 30 days after classes
begin if the Immunization Documentation and Medi-
cal History forms have not been received by Student
Health Services (SHS).

- Please obtain all needed immunizations BEFORE
  submitting the form. Required immunizations are
  available at local health departments.

- KEEP COPY OF ALL IMMUNIZA-
  TION RECORDS FOR YOUR PERSONAL FILES.

- You will be informed of any missing information.

Some PROGRAMS may require their department to re-
ceive additional immunizations. Contact your de-
partment for specifications. If the Varicella immu-
unization is required, complete SECTION B of the IMMUN-
IZATION FORM. Copies of immunization records or
blood titers are acceptable of both.

NOTE: Some departments may require a copy of this
Medical History form. IT IS YOUR RESPONSIBILITY
TO PROVIDE YOUR PROGRAM WITH A COPY.

"To serve OUR STUDENTS"
PHYSICAL EXAMINATION  (Please print in black ink) To be completed and signed by physician or clinic.

A physical examination is required by some schools and/or programs (consult your college and department for specific requirements). If required, it must be completed in black ink and signed by a physician or clinic.

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle Name</th>
<th>Date of birth (mo/day/year)</th>
<th>*Social Security Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Permanent Address</th>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Area Code/Phone Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Height _______  Weight _______  TPR _______ /  /  /  BP _______ /  /  /

IF REQUIRED:
Vision: Corrected Right 20/____ Left 20/____
Uncorrected Right 20/____ Left 20/____
Color Vision _______

Hearing (gross) Right _______  Left _______

STSI (may be required by some departments)
Date _______ Results _______

Recommendations _______

Are there abnormalities?

<table>
<thead>
<tr>
<th>Normal</th>
<th>Abnormal</th>
<th>DESCRIPTION (attach additional sheets if necessary)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Head, Ears, Nose, Throat</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Eyes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Respiratory</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Cardiovascular</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Gastrointestinal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Hernia</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Genitourinary</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Musculoskeletal</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Metabolic/Endocrine</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Neuropsychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. Skin</td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Mammary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A. Is there a loss or seriously impaired function of any paired organs? Yes _______  No _______

Explain _______

B. Is the student under treatment for any medical or emotional condition? Yes _______  No _______

Explain _______

C. Recommendation for physical activity (physical education, intramurals, etc.) Unlimited _______  Limited _______

Explain _______

D. Is student physically and emotionally healthy? Yes _______  No _______

Explain _______

* Only for Students Admitted to a HEALTH SCIENCES PROGRAM*

Based on my assessment of this student’s physical and emotional health on _________, he/she appears able to participate in the activities of a health profession in a clinical setting. Yes _______  No _______ If no, explain _______

Signature of Physician/Physician Assistant/Nurse Practitioner _______

Date _______

Print Name of Physician/Physician assistant/Nurse Practitioner _______

Area Code/Phone Number _______

Office Address _______

City _______

State _______

Zip Code _______

* Provision of Social Security number is voluntary, is requested solely for administrative convenience and record-keeping accuracy, and is requested only to provide a personal identifier for the internal records of this institution.
REPORT OF MEDICAL HISTORY (Please print in black ink) To be completed by student

**LAST NAME** (print) | **FIRST NAME** | **MIDDLE NAME** | FSU Student ID Number | **SOCIAL SECURITY NUMBER**
--- | --- | --- | --- | ---

**PERMANENT ADDRESS** | **CITY** | **STATE** | **ZIP CODE** | **AREA CODE/PHONE NUMBER**
--- | --- | --- | --- | ---

**DATE OF BIRTH** (mo/day/yr) | **GENDER** | **M** | **F** | **MARITAL STATUS** | **S** | **M** | **OTHER** | **EMAIL**
--- | --- | --- | --- | --- | --- | --- | --- | ---

**CLASS YOU ARE ENTERING** (circle): | **PREVIOUSLY ENROLLED HERE** | **YES** | **NO** | **SEMESTER ENTERING** (circle): | **FALL** | **SPRING** | **SUMMER 1** | **SUMMER 2** | **OTHER** | **YEAR** | **20**
--- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | ---

**HOSPITAL/HEALTH INSURANCE (NAME AND ADDRESS OF COMPANY)** | **AREA CODE/TELEPHONE NUMBER**
--- | ---

**NAME OF POLICY HOLDER** | **SOCIAL SECURITY NUMBER** | **EMPLOYER**
--- | --- | ---

**POLICY OR CERTIFICATE NUMBER** | **GROUP NUMBER** | **IS THIS AN HMO/PPO/MANAGED CARE PLAN?** | **YES** | **NO**
--- | --- | --- | ---

**NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY** | **RELATIONSHIP** | **ADDRESS** | **CITY** | **STATE** | **ZIP CODE** | **AREA CODE/PHONE NUMBER**
--- | --- | --- | --- | --- | --- | ---

The following health history is confidential, does not affect your admission status and, except in an emergency situation or by court order, will not be released without your written permission. Please attach additional sheets for any items that require fuller explanation.

**FAMILY & PERSONAL HEALTH HISTORY** (Please print in black ink) To be completed by student

Has any person, related by blood, had any of the following:

<table>
<thead>
<tr>
<th>High blood pressure</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heart attack before age 55</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood clotting disorder</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cholesterol or blood fat disorder</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Glaucoma</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cancer (type):</th>
<th>Yes</th>
<th>No</th>
<th>Relationship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol/drug problems</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatric illness</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Suicide</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Height</th>
<th>Weight</th>
</tr>
</thead>
</table>

Have you ever had or have you now (please check at right of each item and if yes, indicate year of first occurrence):

<table>
<thead>
<tr>
<th>High blood pressure</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
<th>Hay fever</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
<th>Jaundice or hepatitis</th>
<th>Yes</th>
<th>No</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatic fever</td>
<td></td>
<td></td>
<td></td>
<td>Allergy injection therapy</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Rectal disease</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Heart trouble</td>
<td></td>
<td></td>
<td></td>
<td>Arthritis</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Severe or recurrent abdominal pain</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Pain or pressure in chest</td>
<td></td>
<td></td>
<td></td>
<td>Concussion</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Hemia</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Shortness of breath</td>
<td></td>
<td></td>
<td></td>
<td>Frequent or severe headache</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Easy fatigability</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td>Dizziness or fainting spells</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Anemia or Sickle Cell Anemia</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Pneumonia</td>
<td></td>
<td></td>
<td></td>
<td>Severe head injury</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Eye trouble besides need glasses</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Chronic cough</td>
<td></td>
<td></td>
<td></td>
<td>Paralysis</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Bone, joint, or other deformity</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Head or neck radiation treatments</td>
<td></td>
<td></td>
<td></td>
<td>Disabling depression</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Knee problems</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Tumor or cancer (specify)</td>
<td></td>
<td></td>
<td></td>
<td>Excessive worry or anxiety</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Recurrent back pain</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Malaria</td>
<td></td>
<td></td>
<td></td>
<td>Ulcer (duodenal or stomach)</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Neck injury</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Thyroid trouble</td>
<td></td>
<td></td>
<td></td>
<td>Intestinal trouble</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Back injury</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td>Pilonidal cyst</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Broken bone (specify)</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Serious skin disease</td>
<td></td>
<td></td>
<td></td>
<td>Frequent vomiting</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Kidney infection</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
<tr>
<td>Mononucleosis</td>
<td></td>
<td></td>
<td></td>
<td>Gall bladder trouble or gallstones</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
<td>Other (specify)</td>
<td>Yes</td>
<td>No</td>
<td>Year</td>
</tr>
</tbody>
</table>

Please list any drugs, medicines, birth control pills, vitamins, minerals, and any herbal/natural product (prescription and nonprescription) you use and how often you use them.

<table>
<thead>
<tr>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
<th>Name</th>
<th>Use</th>
<th>Dosage</th>
</tr>
</thead>
</table>

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FAMILY & PERSONAL HEALTH HISTORY-CONTINUED

Check each item "Yes" or "No." Every item checked "Yes" must be fully explained in the space on the right (or on an attached sheet).

Have you ever experienced adverse reactions (hypersensitivities, allergies, upset stomach, rash, hives, etc.) to any of the following? If yes, please explain fully the type of reaction, your age when the reaction occurred, and if the reaction has occurred more than once.

<table>
<thead>
<tr>
<th>Adverse Reactions to:</th>
<th>Yes</th>
<th>No</th>
<th>Explanation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Penicillin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sulfa</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other antibiotics (name)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aspirin</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Codeine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other pain relievers</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other drugs, medicines, chemicals (specify)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Insect bites</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Food allergies (name)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Do you have any conditions or disabilities that limit your physical activities? (If yes, please describe)

Have you ever been a patient in any type of hospital? (Specify when, where, and why)

Has your academic career been interrupted due to physical or emotional problems? (Please explain)

Is there loss or seriously impaired function of any paired organs? (Please describe)

Other than for routine check-up, have you seen a physician or health-care professional in the past six months? (Please describe)

Have you ever had any serious illness or injuries other than those already noted? (Specify when and where and give details)

IMPORTANT INFORMATION....PLEASE READ AND COMPLETE

STATEMENT BY STUDENT (OR PARENT/GUARDIAN, IF STUDENT UNDER AGE 18):

(A) I have personally supplied (reviewed) the above information and attest that it is true and complete to the best of my knowledge. I understand that the information is strictly confidential and will not be released to anyone without my written consent, unless otherwise permitted by law. If I should be ill or injured or otherwise unable to sign the appropriate forms, I hereby give my permission to the institution to release information from my (son/daughter’s) medical record to a physician, hospital, or other medical professional involved in providing me (him/her) with emergency treatment and/or medical care.

(B) I hereby authorize any medical treatment for myself (my son/daughter) that may be advised or recommended by the physicians of the Student Health Service. (Not applicable to community colleges.)

(C) I am aware that the Student Health Service charges for some services and I may be billed through the University Cashier if the account is not paid at the time of visit. I accept personal responsibility for settling the account with the Cashier and for payment of incurred charges. I am responsible for filing outpatient charges with insurance and acknowledge that my responsibility to the university is unaffected by the existence of insurance coverage. (Not applicable to community colleges.)

Student Name (print)  

Signature of Student  

FSU Student ID Number  

Date  

Signature of Parent/Guardian, if student under age 18  

Date  

Page 4
GUIDELINES FOR COMPLETING IMMUNIZATION RECORD

IMPORTANT – The immunization requirements must be met; or according to NC law, you will be withdrawn from classes without credit.

Be certain that your Name, Date of Birth, and ID Number appear on each sheet and that all forms are mailed together. The records must be in black ink and the dates of vaccine administration must include the month, day, and the year.

Please Keep a Copy for Your Records.

Your Immunizations may be obtained from any of the following:

- High School Records – Although not official, these may contain some, but not all of your immunization information. Your immunization records do not transfer automatically. You must request a copy.
- Personal Shot Records – Must be verified by a doctor’s stamp or signature or by a clinic or health department stamp.
- Local Health Department
- Military Records of WHO (World Health Organization Documents) - These records may not contain all of the required immunizations.
- Previous College or University – Your immunization records do not transfer automatically. You must request a copy.

SECTION A: COLLEGE/UNIVERSITY VACCINES AND NUMBER OF DOSES REQUIREMENTS
(For further information: http://www.immunizenc.com/college.htm)

<table>
<thead>
<tr>
<th></th>
<th>Diphtheria, Tetanus and/or Pertussis¹</th>
<th>Polio²</th>
<th>Measles³</th>
<th>Mumps⁴</th>
<th>Rubella⁵</th>
<th>Hepatitis B⁶</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>3</td>
</tr>
</tbody>
</table>

FOOTNOTE ¹ – DTP (Diphtheria, Tetanus, Pertussis), DTap (Diphtheria, Tetanus, acellular Pertussis), Td (Tetanus, Diphtheria), Tdap (Tetanus, Diphtheria, Pertussis): 3 doses of tetanus/diphtheria toxoid of which one must have been within the past 10 years.

Those individuals enrolling in college or university for the first time on or after July 1, 2008 must have had three doses of tetanus/diphtheria toxoid and a booster dose of tetanus/diphtheria/pertussis vaccine if a tetanus/diphtheria toxoid and tetanus/diphtheria/pertussis vaccine has not been administered with the past 10 years.

FOOTNOTE ² – An individual attending school who has attained his or her 18th birthday is not required to receive polio vaccine.

FOOTNOTE ³ – Measles vaccines are not required if any of the following occur: Physician diagnosis of disease prior to January 1, 1994; An individual who has been documented by serological testing to have a protective antibody titer against measles and submits the lab report; or An individual born prior to 1957. An individual who enrolled in college or university for the first time before July 1, 1994 is not required to have a second dose of measles vaccine.

FOOTNOTE ⁴ – Mumps vaccine is not required if any of the following occur: An individual who has been documented by serological testing to have a protective antibody titer against mumps and submits the lab report; An individual born prior to 1957, or enrolled in college or university for the first time before July 1, 1994. An individual entering college or university prior to July 1, 2008 is not required to receive a second dose of mumps vaccine.

FOOTNOTE ⁵ – Rubella vaccine is not required if any of the following occur: 50 years of age or older; Enrolled in college or university before February 1, 1989 and after their 30th birthday; An individual who has been documented by serological testing to have a protective antibody titer against rubella and submits the lab report.

FOOTNOTE ⁶ – Hepatitis B vaccine is not required if any of the following occur: Born before July 1, 1994.

INTERNATIONAL STUDENTS and/or non-US Citizens: Vaccines are required as noted above. Additionally, these students are required to have a Tb skin test (PPD or TST) that has been administered and read at an appropriate medical facility within the 12 months prior to the first day of class. (Chest x-ray required if test is positive)

SECTION B

These vaccines are RECOMMENDED. Some may be required by certain departments. Consult your college or department for specific requirements.

North Carolina House Bill 825 requires public and private institutions with on-campus residents to provide information about meningococcal disease. Attached to this form is information regarding meningococcal disease, including recommendations from the Centers for Disease Control of the U.S. Public Health Service. Please record on the front of this form, whether or not you have received the meningococcal vaccine. If, yes, please note the month, day, and year of the vaccination.
### FAYETTEVILLE STATE UNIVERSITY - IMMUNIZATION RECORD

#### SECTION A REQUIRED IMMUNIZATIONS

All students must submit documentation of 3 DTP, Td or Tdap vaccines regardless of age. **One MUST be a Tdap.**

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>DTaP/DTP/Td (Diphtheria/Tetanus/Pertussis or Tetanus/Diphtheria Toxoid)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tdap booster (All Students MUST show proof of a Tdap booster)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio (3 doses, only required if 17 years of age or younger)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MMR (Measles, Mumps, Rubella – 2 MMR vaccines required on or after first birthday OR 2 Measles, 2 Mumps and 1 Rubella single doses OR positive Measles, Mumps, Rubella titers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles (2 required on or after first birthday OR positive titer OR documented disease date)</td>
<td></td>
<td></td>
<td>Disease Date</td>
<td>**Titer Date &amp; Result</td>
</tr>
<tr>
<td>Mumps (2 required on or after first birthday OR positive titer)</td>
<td></td>
<td></td>
<td>(Disease Date NOT Accepted)</td>
<td>**Titer Date &amp; Result</td>
</tr>
<tr>
<td>Rubella (1 required on or after first birthday OR positive titer)</td>
<td></td>
<td></td>
<td>(Disease Date NOT Accepted)</td>
<td>**Titer Date &amp; Result</td>
</tr>
<tr>
<td>Hepatitis B Series (only required if born after July 1, 1994)</td>
<td></td>
<td></td>
<td></td>
<td>Titer NOT Accepted for required Hep B Series</td>
</tr>
</tbody>
</table>

#### SECTION B RECOMMENDED IMMUNIZATIONS

<table>
<thead>
<tr>
<th>Immunization Name</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
<th>MM/DD/YYYY</th>
</tr>
</thead>
</table>

Has the student received the Meningococcal vaccine (Menactra, Menveo, Menomune, MPSV4, MCV4)?  
☐ Yes  ☐ No

If Yes, date(s) received - Booster dose recommended at age 16

Meningococcal B vaccine (Bexsero or Trumenc - Please discuss risks and benefits of this vaccine with your medical provider)

Hepatitis A

Hepatitis A/B combination series

Pneumococcal

Human Papillomavirus (HPV)  
- Cervarix
- Gardasil
- Gardasil-9

Varicella (2 doses, documentation of disease date or positive titer)

Tuberculin Skin Test (TST)

Date Read

| mm in induration | mm | mm |

Date of IGRA (QuantIFERON or T-SPOT) test

Result of IGRA test

| Positive | Negative | Positive | Negative |

**Titer Date & Result

**Chest X-ray Date

**Chest X-ray Result

Positive  Negative

** Must attach a copy of all laboratory and Chest X-ray results

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Signature and Credentials of Health Care Provider

Printed Name and Credentials of Health Care Provider

Office Address  
City  
State  
Zip Code

Date

Area Code/Phone Number