IMMUNIZATIONS REQUIRED

STUDENT'S NAME_____ Date of Birth (mm/dd/yyyy) ____/____/_____

1. Please fill out the form below with the dates the shots/disease occurred based on your immunization paperwork.
2. You also need to provide your immunization paperwork/card from a health facility/doctor. It must have an official stamp.
3. Provide an English translation of your immunization record.
4. Please obtain all the required immunzations before departure from your home country. You will not be allowed to attend classes until this requirement has been met.

IMMUNIZATIONS NEEDED:

A. Four doses of polio vaccine (TOPV) (3 doses are acceptable if one given after child's 2nd birthday)
B. Four doses of Diphtheria, Tetanus, and Pertussis – DPT, Td, Dt, or DTaP for ages 7-17 (3 doses are acceptable if one was given after child's 2nd birthday)
C. Two doses of MMR (1 dose acceptable if given after the 1st birthday)
D. Three doses of Hepatitis B vaccine (2 doses are acceptable if the 2-dose Hepatitis B formulation is given)
E. One dose of Varicella vaccine (2 doses required if first dose given after the thirteenth birthday. 'Had disease' is also acceptable if verified by a doctor)
F. One dose of Booster shot of Tdap, DTaP or DTP (for Pertussis) is required after child's 7th birthday. Td dose does not meet this requirement.

VACCINE	DATES (mm/dd/yyyy)				
A. TOPV/OPV or IPV (Polio)	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	
B. DTP/DTaP/DT or Td (Diphtheria, Tetanus and Pertussis)	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____	4th ____/____/_____	
C. MMR (Measles, Mumps, Rubella)	1st ____/____/_____	2nd ____/____/_____			OR had disease: Dr.'s signature _____
D. Hepatitis B	1st ____/____/_____	2nd ____/____/_____	3rd ____/____/_____		
E. Varicella (Chickenpox)	1st ____/____/_____	2nd (Required if first shot given after 13th birthday) ____/____/_____			OR had disease: Dr.'s signature _____
F. Pertussis Booster – Tdap (whooping cough)	1st After 7th birthday ____/____/_____				

_____ _____

Signature of Physician Date

Official Seal/Stamp Here

Revised 12/04/17