A. MMR (MEASLES, MUMPS, RUBELLA) (REQUIRED)
(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)
Dose 1 given at 12 months of age or later: _______ / _______
Dose 2 given at least 28 days after Dose 1: __________ / __________

B. POLIO
1. Completed primary series of polio immunizations: □ Yes □ No
   Date of last booster: __________ / __________
2. Type of vaccine: □ Oral (OPV) □ Injected (IPV) □ IPV/OPV Sequential

C. VARICELLA (CHICKENPOX)
1. History of Disease: □ Yes □ No
   Varicella antibody: _______/______
   Result: ______________________
2. Vaccinated: Dose 1 _______/_______
   Dose 2 _______/_______
   (at least 12 weeks after Dose 1 for ages 1-12 years and at least 4 weeks for ages 13 and older)

D. TETANUS-DIPHTHERIA – PERTUSSIS (BOOSTER IN LAST 10 YEARS REQUIRED)
1. Completed primary series of Tetanus-Diphtheria: □ Yes □ No
   Date of most recent booster: _______/_______
   Date of last dose in series: _______/_______
   Type of booster: Td____ Tdap _______
   Tdap booster recommended for ages 11-64 unless contraindicated.

E. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 OR HPV4)
(Three doses of vaccine for females and males 11-26 years of age at 0, 1-2, and 6 month intervals.)
Immunization (indicate which preparation): _______ Quadrivalent (HPV4) or _______ Bivalent (HPV2)
1. Dose 1: _______/_______
   Dose 2: _______/_______
   Dose 3: _______/_______
2. NOT IMMUNIZED

F. HEPATITIS A
1. Immunization (hepatitis A)  
   Dose 1: _______/_______
2. Immunization (Combined hepatitis A and B vaccine)  
   Dose 1: _______/_______
   Dose 2: _______/_______
   Dose 3: _______/_______

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G. HEPATITIS B
(All college and health care professional students. Three doses of vaccine or two doses of adult vaccine in adolescents 11-15 years of age, or a positive hepatitis B surface antibody meets the requirement.)

1. Immunization (hepatitis B)
   Dose 1: _____ / _____ / _____
   M D Y
   Dose 2: _____ / _____ / _____
   Adult formulation Child formulation
   M D Y
   Dose 3: _____ / _____ / _____
   Adult formulation Child formulation
   M D Y

2. Immunization (Combined hepatitis A and B vaccine)
   Dose 1: _____ / _____ / _____
   M D Y
   Dose 2: _____ / _____ / _____
   M D Y
   Dose 3: _____ / _____ / _____
   M D Y

3. Hepatitis B surface antibody
   Date _____/_____/_____
   Result: Reactive _____ Non-reactive_____

4. NOT IMMUNIZED_____

H. PNEUMOCOCCAL POLYSACCHARIDE VACCINE
(One dose for members of high-risk groups.)

1. Date: __________/_______/_____
   M D Y

2. NOT IMMUNIZED_____

I. MENINGOCOCCAL QUADRIVALENT
(A, C, Y, W-135) One or two doses for all college students - revaccinate every five years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible.)
   Dose 1: _____ / _____/_____ Dose 2: _____ / _____/_____ Dose 3: _____/_____/_____ M D Y
   M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available.)
   Date: _____/_____/_____
   M D Y

3. NOT IMMUNIZED_____

HEALTH CARE PROVIDER
Name __________________________________________ Date / /  
M D Y
Address ________________________________________________________________________________

MD Signature (required) __________________________________________ Phone ( ) ______________________________

Name of Student __________________________________________ Date of Birth _____/_____/_____
M D Y
I, the undersigned student, have read and understand the information provided to me about Meningococcal Meningitis and Hepatitis B. I understand the benefits and risks of being vaccinated against these diseases. The information provided on this form regarding my vaccination status is accurate and is being provided in compliance with the Ohio Revised Code, Section 3701.133, (B).

Signature __________________________________________ Date / /  
M D Y

Questions?: Health Services (513) 244-4769 health_services@mail.msj.edu