IMMUNIZATION RECORD

Required of all students

Name:____ **SSN:**__ __ __ - __ __ - __ __ __ __
Last *First* *MI* *Preferred name*

Address:____
Street *City* *State* *Zip*

Date of Birth:____/____/________ **Enrolling:**_____ Year ☐ Fall ☐ Jan Term ☐ Spring ☐ Summer

M.M.R. (Measles, Mumps and Rubella)
Born before 1957, no immunization required

M.M.R (Measles,Mumps,Rubella)	#1 ____________ month/ day/ year	#2 ____________ month/day/year

OR

MEASLES: (Rubeola) Two doses required OR positive *immune titer.
MUMPS: One dose required OR report of positive *immune titer.
RUBELLA: One dose required OR report of positive *immune titer.

Measles	#1 ____________ month/day/year	#2 ____________ month/day/year	Titer results and date ____________ *attach report copy
Mumps	#1 ____________ month/day/year	Titer Result and date____________ *attach copy of titer report	
Rubella	#1 ____________ month/day/year	Titer results and date____________ *attach copy of titer report	

TETANUS-DIPHTHERIA

Tetanus Diphtheria Booster ***within the last 10 years***	________________ month/ day/ year

TUBERCULOSIS SCREENING

1. Does the student have signs or symptoms of active tuberculosis disease?
   Yes [ ] No [ ] **If No**, proceed to 2.
   If yes, proceed with additional evaluation to exclude active tuberculosis disease including tuberculin skin testing, chest x-ray and sputum evaluation as indicated.

2. Is the student a member of a high risk group* or is the student entering a health profession? Yes [ ] No [ ] **If No**, stop. **If yes**, proceed to 3.

3. PPD Skin Test (Mantoux):
   Date Given: ______________ Date Read: ______________ Results: (mm induration) __________________ **If positive**, proceed to 4.
   month/day/year month/day/year

4. Chest x-ray (required if PPD is positive) Date of Chest x-ray: _______________ Results: Normal [ ] Abnormal [ ]

*High risk students include those who have arrived within the past 5 years from any country EXCEPT: Western Europe, Canada, Australia or New Zealand. Additional high-risk categories include those with HIV infection or other immunosuppressive disorders, h/o IV drug use, or those who have resided in, or worked in high-risk congregate settings such as prisons, shelters, hospitals, nursing homes, etc.

REQUIRED OF ALL FRESHMEN LIVING ON CAMPUS (*In addition to the above*)

VARICELLA (Chickenpox) Date of disease OR Vaccination

Date of Disease	____________ Month Year	
Immunization	#1 ____________ Month Day Year	#2 ____________ Month Day Year

MENINGOCOCCAL

Immunization	____________ Month Day Year

REQUIRED OF ALL PHARMACY, NURSING AND ATHLETIC TRAINING STUDENTS; Recommended for all students

HEPATITS B

#1 ____________ Month Day Year	#2 ____________ Month Day Year	#3 ____________ Month Day Year	Hepatitis B Surface Antibody	____________ Month Day Year	RESULT: [ ] Reactive [ ] Non-Reactive

THIS RECORD MUST BE SIGNED BY A HEALTH CARE PROVIDER (Health Department stamp acceptable)

MD/PA/NP/RN Signature: ________________________________ Date:________________________

Print Name: ________________________________ Phone: ( ) ________________________

Address: ____

RETURN THIS FORM TO: **Samford University Student Health Services**
800 Lakeshore Drive ● Birmingham, AL 35229

IMPORTANT: Make a copy of this record for your personal files