

Immunization Record for Ohio Wesleyan University Health Center

Name: _____

Date of birth: ____/____/____

Items A-E are **REQUIRED** to be completed **prior to attending classes**.

Items F-I are **highly recommended** for everyone.

Items J-M are recommended for members of certain higher risk groups or those who plan to study abroad or travel overseas.

REQUIRED VACCINES:

A: TETANUS, DIPHTHERIA, PERTUSSIS (DTP, DTaP, DT, Td or Tdap) - Items 1 and 2 are REQUIRED:

1. Primary series of four to five doses of either DTaP or DT, with the final dose being after age 4 years.

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____
M D Y M D Y M D Y

#4 ____/____/____ #5 ____/____/____
M D Y M D Y

2. Most recent DTaP or TDr (**within the last 10 years**): ____/____/____ Brand of booster: Td ____ Tdap ____
M D Y

B: MEASLES, MUMPS, RUBELLA (MMR) – Two doses are required with one or more being after age 4 years.

1. Dose #1 ____/____/____ 2. Dose #2 ____/____/____
M D Y 28 days after #1 M D Y

If Measles, Mumps and Rubella vaccines were given separately, that is acceptable as long as 2 of each were completed; please list vaccines and dates.

C: POLIO

At least three doses are required, with the final dose being administered after age 4 years. Please indicate if each dose was either OPV or IPV.

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____
M D Y M D Y M D Y M D Y
OPV or IPV OPV or IPV OPV or IPV OPV or IPV

#5 ____/____/____
OPV or IPV

D: HEPATITIS B

Two to Three doses based on the brand received.

Dose #1 ____/____/____
M D Y

Dose #2 ____/____/____
M D Y

Dose #3 ____/____/____
M D Y

Brand: _____

Brand: _____

Brand: _____

M D Y

E: MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

At least one dose required, but students younger than 22 years need a MCV booster dose if their previous dose was given before age 16 years.

1. Dose #1 ____/____/____ 2. Dose #2 ____/____/____
M D Y M D Y

Brand: _____

Brand: _____

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Recommended but not required vaccines:

F: VARICELLA

Two doses of vaccine is recommended unless a history of chicken pox, or born in the US before 1980.

1. History of Disease Yes ☐ No ☐

2. Immunization

a. Dose #1 / /
M D Y

b. Dose #2 / /
M D Y

G: HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)

Two doses if administered prior to age 14 or three doses if administered after the age of 14.

Circle formula received: Gardasil Gardasil 9 or Cervarix

a. Dose #1 / /
M D Y

b. Dose #2 / /
M D Y

c. Dose #3 / /
M D Y

H: INFLUENZA – Recommended yearly

Most Recent Dose / /
M D Y

I: SEROGROUP B MENINGOCOCCAL

MenB-RC (Bexsero) ☐ Routine ☐ Outbreak Related

Dose #1 / /
M D Y

2. Dose #2 / /
M D Y

OR

MenB-FHbp (Trumenba) ☐ Routine ☐ Outbreak Related

a. Dose #1 / /
M D Y

b. Dose #2 / /
M D Y

c. Dose #3 / /
M D Y

J: PNEUMOCOCCAL POLYSACCHARIDE VACCINE

One dose recommended for students with certain medical conditions: asthma, current history of smoking, diabetes, immunosuppression

Date / /
M D Y

K: HEPATITIS A

Recommended for all adolescents through the age of 18, for international travel, and for those who are considered part of at-risk populations for Hepatitis A virus.

1. Dose #1 / / Dose #2 / /
M D Y M D Y

L: TYPHOID

For students who intend to study abroad or travel overseas

Date of last dose: / /
M D Y



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for Ohio Wesleyan University Health Center

M: YELLOW FEVER

For students who intend to study abroad or travel overseas

Date of last dose ____/____/____
 M D Y

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____
 _____ Fax (_____) _____

Please return to: OWU Student Health Center ♦ Stuyvesant Hall ♦ Delaware, Ohio 43015

Phone (740) 368-3160 ♦ Fax (614) 366-2781 ♦ primarycareohiowesleyan@osumc.edu