Items A-E are **REQUIRED** to be completed *prior to attending classes*.  
Items F-J are **highly recommended** for everyone.  
Items K-N 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 doses of either DTaP, DT, DTP or Td  #1 M D Y #2 M D Y #3 M D Y #4 M D Y  
2. Most recent booster (*must be within 10 years*): M D Y Type of booster: Td Tdap  

**B: MEASLES, MUMPS, RUBELLA (MMR)** – Two doses are required.  
1. Dose #1 M D Y 2. Dose #2 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. Please indicate if each dose was either OPV or IPV.  
#1 M D Y #2 M D Y #3 M D Y #4 M D Y  
OPV or IPV OPV or IPV OPV or IPV OPV or IPV  

**D: HEPATITIS B**  
Three doses of child vaccine, or two doses of adult vaccine in adolescents 11-15 years old, or a positive hepatitis B surface antibody meets the requirement.  
Dose #1 M D Y Dose #2 M D Y Dose #3 M D Y  
Formulation: Child or Adult (Please circle one)  
OR Hepatitis B surface antibody Date M D Y Result: Reactive Non-reactive  

**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 M D Y 2. Dose #2 M D Y  
Type: Type:  

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Recommended but not required vaccines:

**F: COVID 19 VACCINE**

Pzifer Dose #1 ___/___/_____  Dose # 2 ___/___/_____  or  Moderna Dose #1 ___/___/_____  Dose #2 ___/___/_____
or Johnson and Johnson ___/___/_____
PLUS
Booster Dose ___/___/_____

**G: 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 ___/___/_____
   b. Dose #2 ___/___/_____

**H: HUMAN PAPILLOMAVIRUS VACCINE (HPV2 or HPV4)**

Three doses of vaccine recommended for females and males 11-26 years of age

Circle formula received:  Gardasil  Gardasil 9  or  Cervarix

a. Dose #1 ___/___/_____
   b. Dose #2 ___/___/_____
   c. Dose #3 ___/___/_____

**I: INFLUENZA – Recommended yearly**

**J: SEROGROUP B MENINGOCOCCAL**

MenB-RC (Bexsero)  ___ Routine  ___ Outbreak Related
Dose #1 ___/___/_____
Dose #2 ___/___/_____

OR

MenB-FHbp (Trumenba)  ___ Routine  ___ Outbreak Related
a. Dose #1 ___/___/_____
   b. Dose #2 ___/___/_____
   c. Dose #3 ___/___/_____

**K: PNEUMOCOCCAL POLYSACCHARIDE VACCINE**

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

Date ___/___/_____

**L: HEPATITIS A**

Recommended for routine use in all adolescents through the age of 18, for students traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, etc.

1.  Dose #1 ___/___/_____
    Dose #2 ___/___/_____

M D Y M D Y
Immunization Record
for Ohio Wesleyan University Health Center

M: TYPHOID
For students who intend to study abroad or travel overseas
Date of last dose: ___/___/______

N: YELLOW FEVER
For students who intend to study abroad or travel overseas
Date of last dose ___/___/______

*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 (740) 368-3166 ◊ health@owu.edu