Immunization Record
for Ohio Wesleyan University Health Center

Name: ____________________________________________ Date of birth: ____/____/_____

Items A–F are **REQUIRED** to be completed prior to attending classes.
Items G–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: ___/___/______
   - #2: ___/___/______
   - #3: ___/___/______
   - #4: ___/___/______

2. Most recent booster (must be within 10 years): ___/___/______
   Type of booster: Td _____ Tdap _____

**B: MEASLES, MUMPS, RUBELLA (MMR)** – Two doses are required.

1. Dose #1: ___/___/______
2. Dose #2: ___/___/______
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.

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<td>OPV or IPV</td>
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**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.

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<th>Dose #1</th>
<th>Dose #2</th>
<th>Dose #3</th>
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Formulation: Child or Adult (Please circle one)

OR Hepatitis B surface antibody Date ___/___/______
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: ___/___/______
2. Dose #2: ___/___/______

Type: ____________________________

**F: COVID 19 VACCINE**

Pzifer Dose #1: ___/___/______
Dose #2: ___/___/______ or
Moderna Dose #1: ___/___/______
Dose #2: ___/___/______
or
Johnson and Johnson: ___/___/______

PLUS

Booster Dose: ___/___/______
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Recommended but not required vaccines:

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 ___/___/________ 2. 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: 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 ___/___/________
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Name: __________________________ Date of birth: ____/_____ /_____

*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