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 doses of either DTaP, DT, DTP or Td #1____/____/_____ #2____/____/_____ #3____/____/_____
   M D Y M D Y M D Y

   #4____/____/_____
   M D Y

2. Most recent booster (**must be within 10years**): ____/____/_____ Type of booster: Td _____ Tdap _____
   M D Y

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

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. 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

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 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____
M D Y M D Y M D Y

Formulation: Child or Adult Child or Adult Child or Adult
(Please circle one) (Please circle one) (Please circle one)

OR Hepatitis B surface antibody Date ____/____/_____ Result: Reactive _____ Non-reactive _____
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

   Type:_____ Type:_____

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 ____/____/_____ b. Dose #2 ____/____/_____

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M D Y M D Y

G: 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 ____/____/_____
M D Y M D Y M D Y

H: INFLUENZA – Recommended yearly

I: SEROGROUP B MENINGOCOCCAL

MenB-RC (Bexsero) ___ Routine ___ Outbreak Related

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

OR

MenB-FHbp (Trumenba) ___ Routine ___ Outbreak Related

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

J: PNEUMOCOCCAL POLYSACCHARIDE VACCINE

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

Date ____/____/_____
M D Y

K: 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

L: TYPHOID

For students who intend to study abroad or travel overseas

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

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 (740) 368-3166 ◊ health@owu.edu