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

   
   
   
   
   
   
   

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.

1. Dose #1 ____/____/________
2. Dose #2 ____/____/________
3. Dose #3 ____/____/________
4. Dose #4 ____/____/________

**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.

1. Dose #1 ____/____/________
2. Dose #2 ____/____/________
3. Dose #3 ____/____/________

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 ____/____/________

**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 ____/____/________
Immunization Record
for Ohio Wesleyan University Health Center

Name: __________________________________________  Date of birth: _____/_____ /_____  

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 _____/_____/_______

H: INFLUENZA – Recommended annually

I: 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 _____/_____/_______

J: PNEUMOCOCCAL POLYSACCHARIDE VACCINE
One dose recommended for students with certain medical conditions: asthma, current history of smoking, diabetes, immunosuppression
Date _____/_____/_______

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 _____/_____/_______

L: TYPHOID
For students who intend to study abroad or travel overseas
Date of last dose: _____/_____/_______

M: YELLOW FEVER
For students who intend to study abroad or travel overseas
Date of last dose: _____/_____/_______

*HEALTH CARE PROVIDER*
Name __________________________________________  Signature ____________________________
Address ____________________________________________________________________________  Phone (_________) ____________________________
__________________________________________________________________________________  Fax (_________) ____________________________