



## Record of Required Immunizations

**Proof of immunization is mandatory for all students living in university housing at UAF. This form signed by a clinician or a copy of your medical record of immunizations must be completed and returned to the Center for Health and Counseling before you enroll.**

If you don't have your immunization record, try getting it from your high school or previous college, your local health department if you received immunizations there, your military immunization record, your pediatrician's office, or from your parents.

**REQUIRED immunizations are indicated by an asterisk ( \* ).**

Any student living in university housing must have ALL of the \* items (Board of Regents policy 09.11.010).

A copy of your official immunization record is acceptable in lieu of completing this form; please attach.

	Date	Results	
Tuberculosis (PPD) Skin Test *			Date must be <u>within one year of UAF admission</u> . If TB test is positive a chest X-ray is required.
Tetanus, Diphtheria, Pertussis— primary series completed	Month	Year	If serious doubt exists about the completion of a primary 3 dose series, 2 doses of 0.5 ml of combined (Td) toxoids should be given one month apart, followed by a third dose in 6–12 months.
Tetanus, Diphtheria Booster or Tetanus, Diphtheria, and Pertusis Booster *	Month	Year	Must be <u>within the past 10 years</u> .
Poliomyelitis series completed	Month	Year	
Measles, Mumps, Rubella (MMR) 1st dose *	Month	Year	Recommended for students born after 1956. Laboratory evidence of immunity is acceptable.
Measles, Mumps, Rubella (MMR) 2nd dose *	Month	Year	A second dose is highly recommended. Laboratory evidence of immunity is acceptable.
Other:	Month	Year	Other immunizations recommended by the American College Health Association include: <ul style="list-style-type: none"> <li>• Varicella (chicken pox) for persons without a history of the disease or without a history of vaccination or positive antibody titer</li> <li>• Hepatitis A (series of 2 vaccines)</li> <li>• Hepatitis B (series of 3 vaccines)</li> <li>• Meningococcal (for freshman students, especially those living in dormitories)</li> <li>• Human papilloma virus (HPV) (for females ages 11-26; series of 3 vaccines)</li> </ul>

### Certification of Dates of Immunization and Freedom from Active Tuberculosis

Signature of clinician or public health official \_\_\_\_\_ Date \_\_\_\_\_

Printed name and address \_\_\_\_\_

\_\_\_\_\_

Student signature \_\_\_\_\_ Date \_\_\_\_\_

### If student is under 18 years of age:

I hereby give the Center for Health & Counseling permission to give my son/daughter medical treatment, counseling and/or appropriate immunizations.

Parent or guardian signature \_\_\_\_\_ Date \_\_\_\_\_

**Note: This page is intentionally printed upside-down to accommodate top-loading medical chart binders.**

FALL 2009-SPRING 2010 Place in Confidential envelope, Mail in BUSINESS REPLY ENVELOPE