HOWARD UNIVERSITY STUDENT HEALTH CENTER
WASHINGTON, DC 20059
Fax (202) 806-7416 Phone (202) 806-7540

IMMUNIZATION HISTORY RECORD FOR NON HEALTH PROFESSIONS STUDENT ONLY

GUIDELINES FOR COMPLETION

- **This immunization record form must be completed and must include a medical provider's signature, health department stamp, or attachment of high school records and/or medical military record. These records may not fulfill all requirements as listed below.**
- **Records must be documented in black ink and all corrections must be signed.**
- **All vaccine dates must include month, day and year of administration.**
- **This immunization record form must be returned or faxed to the Student Health Center immediately upon acceptance to HU.**
- **You will remain on medical hold and will not be allowed to register until all requirements are met. It is your responsibility to ensure that all appropriate sections of this form are completed.**

____

Last Name   First Name   Middle Name   Date of Birth (mo/day/yr)   Student Identification Number

TUBERCULOSIS SCREENING: **A PPD-Mantoux test must be placed and interpreted by a healthcare provider within 6 months of registration.** A student who was previously given the BCG vaccine should also receive the a PPD skin test.

Date skin test placed ____/____/______   Date skin test read____/____/____   Reading in mm induration: ________mm

IF THE SKIN TEST IS POSITIVE OR STUDENT HAS A HISTORY OF A POSITIVE SKIN TEST, THEN A COPY OF CHEST X-RAY RESULTS WITHIN THE LAST 6 months IS REQUIRED.

Date of chest x-ray ____/____/______   **Submit copy of CXR report.**

Date of previous positive skin test ____/____/____   Patient received INH: ___NO ___ YES   Duration of treatment ___________ months

____

REQUIRED IMMUNIZATIONS:

POLIO: Three doses of polio vaccine are required for anyone **under the age of 18** at the time of registration.

Date of dose #1 ____/____/____   Date of dose #2 ____/____/____   Date of dose #3 ____/____/____

TETANUS/DIPHTHERIA: Three doses of Diphtheria/Tetanus/Pertussis (DPT or DTaP or DT) in childhood and a booster of Tetanus/Diphtheria (Td) within the last ten years. **Immune titers for Td are not acceptable**.

Date of dose #1____/____/____   Date of dose #2 ____/____/____   Date of dose #3 ____/____/____

Date of booster dose ____/____/______ must be within the last 10 years or recent Tdap   **Tdap:** Date of dose ____/____/____

MEASLES /MUMPS / RUBELLA (MMR): Two doses required. HISTORY OF DISEASE IS NOT ACCEPTABLE.
If you were born before 1957 and are not enrolled in the health sciences, you are exempt from the MMR requirement.

MMR: Date of dose #1 ____/____/____ Date of dose #2 ____/____/____   OR   **Measles** Date of dose #1 ____/____/____ Date of dose #2 ____/____/____
Mumps Date of dose #1 ____/____/____ Date of dose #2 ____/____/____
Rubella Date of dose #1 ____/____/____ Date of dose #2 ____/____/____

OR

MMR titer (IgG QUANTITATIVE antibodies): Date of titer ____/____/____ **Submit a copy of lab report for all immune MMR titers.**
Measles Date of titer____/____/____   **Mumps** Date of titer____/____/______   **Rubella** Date of titer____/____/____

HEPATITIS B SERIES: Three doses required.

Hepatitis B vaccine: Date of dose #1 ____/____/____   Date of dose #2 ____/____/____   Date of Dose #3 ____/____/____.

OR

Hepatitis B titer (IgG QUANTITATIVE antibodies); Date of titer ____/____/____ **Submit a copy of lab report for immune Hepatitis titer**.

VARICELLA (CHICKEN POX) SERIES: Two doses required.
Varicella vaccine: Date of dose #1 ____/____/____   Date of dose #2 ____/____/____

OR

Varicella titer (IgG QUANTITATIVE antibodies): Date of titer ____/____/____ **Submit a copy of lab report for immune Varicella titer.**

OR

HISTORY OF CHICKENPOX IS ACCEPTABLE ONLY when it is documented by a medical provider with **month/year** of disease recorded on this form.
History of Chicken Pox: Date: ____/____/____

MENINGOCOCCAL vaccine: Date of dose ____/____/____

____

Print Name of Health Care Provider or Clinician   **Signature / Health Department Stamp Date**

Office/ Clinic Name   **Office/Clinic Address**   **Office/Clinic Area Code & Phone Number**

Return or fax all information to:
Howard University Student Health Center
2139 Georgia Avenue, N.W.
Washington, D.C. 20059
Phone (202)-806-7540 / Fax (202)-806-7416