

IMMUNIZATION HISTORY RECORD FOR HEALTH PROFESSIONS STUDENTS ONLY

- This immunization record form must be completed and must include a medical provider's signature, health department stamp. OR
- You may submit copies of high school records and/or medical military record; these records may not fulfill all requirements as listed.
- Records must be documented in black ink and all corrections must be signed.
- Proof of immunizations requires documentation of QUANTITATIVE immune blood titers for MMR, Hepatitis B and Varicella.
 - You must submit a copy of all lab reports for QUANTITATIVE immune titer for MMR, Hepatitis B and Varicella.
 - All dates must include month, day and year for immune titers and/or vaccines 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 PPD skin test. **Please document dates for the last two PPD readings:** Date skin test placed ___/___/___ Date skin test read ___/___/___ Reading in mm induration: _____
Date skin test placed ___/___/___ Date skin test read ___/___/___ Reading in mm induration: _____

PLEASE NOTE THE FOLLOWING SPECIFIC PPD REQUIREMENT!!!

A Two step PPD is required for all Health Professions students if their last PPD was placed > one year ago.

(The second PPD must be placed no earlier than a week after the first PPD but no later than 3 weeks after the first PPD is placed)

Date 1st PPD Placed: ___/___/___ Date PPD Read: ___/___/___ Reading in mm induration: _____mm

Date 2nd PPD Placed: ___/___/___ Date PPD 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 ___/___/___

Must submit copy of CXR report.

Date of previous positive skin test ___/___/___ Patient received INH: ___NO___ YES Duration of treatment _____ months

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 Td booster (< 10 yrs) ___/___/___

Tdap Vaccination (Required if Tetanus (Td) was given more than two years ago) Tdap: Date of dose ___/___/___

MEASLES /MUMPS / RUBELLA (MMR): Submit a copy of lab report for immune titers (IgG QUANTITATIVE antibodies) for MMR.

HISTORY OF DISEASE IS NOT ACCEPTABLE. MMR: Date of titer ___/___/___

Measles Date of titer ___/___/___

Mumps Date of titer ___/___/___

Rubella Date of titer ___/___/___

If the MMR blood titers are non immune, you must submit documentation of dates for one of the following: two doses of a previously completed MMR vaccine plus a booster dose of MMR OR two doses of MMR vaccine with at least one dose given after the non-immune titer. Repeat titers > 1 months after last MMR dose given.

MMR: Date of dose #1 ___/___/___ **OR** Measles Date of dose #1 ___/___/___ Date of dose #2 ___/___/___

Date of dose #2 ___/___/___ Mumps Date of dose #1 ___/___/___ Date of dose #2 ___/___/___

Date of MMR booster ___/___/___ Rubella Date of dose #1 ___/___/___ Date of dose #2 ___/___/___

HEPATITIS B SERIES: Submit a copy of lab report for immune titers (IgG QUANTITATIVE antibodies).

Hepatitis B surface (IgG QUANTITATIVE antibodies): Date of titer ___/___/___

If blood titers are non immune, you must submit documentation of dates for one of the following: three doses of a previously completed Hepatitis B vaccine plus a booster dose of Hepatitis B OR three doses of Hepatitis B vaccine with at least one dose given after the non-immune titer. Repeat titers > 1 months after last Hep B dose given.

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

Date of Hep B booster ___/___/___

VARICELLA (CHICKEN POX) SERIES: Submit a copy of lab report for immune titers (IgG QUANTITATIVE antibodies) for Varicella.

HISTORY OF DISEASE IS NOT ACCEPTABLE. Varicella titer (IgG QUANTITATIVE antibodies): Date of titer ___/___/___

If blood titers are non immune, you must submit documentation of dates for one of the following: two doses of a previously completed Varicella vaccine plus a booster dose of Varicella OR two doses of Varicella vaccine with at least one dose given after the non-immune titer. Repeat titers > 1 months after last VZ dose given.

Varicella vaccine: Date of dose #1 ___/___/___ Date of dose #2 ___/___/___ Date of VZ booster ___/___/___

MENINGOCOCCALVACCINE: Date of vaccine: ___/___/___

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