ALLEGHENY COLLEGE

Immunization Report

Deadline: June 24

This form must be completed and signed by a health care provider.
(Do not attach list)

NAME: Last **First** **MI** **Date of Birth**

REQUIRED IMMUNIZATIONS

REQUIRED VACCINES	Dates Given	Recommended Dosing Schedule
MMR	#1____/____/____ #2____/____/____	2 doses **OR** positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday
Measles	#1____/____/____ #2____/____/____ **OR** Positive Titer Date:____/____/____	Option of combined MMR **OR** Individual vaccines
Mumps	#1____/____/____ #2____/____/____ **OR** Positive Titer Date:____/____/____	
Rubella	#1____/____/____ #2____/____/____ **OR** Positive Titer Date:____/____/____	
Tdap	Tdap ____/____/____	Tdap booster within last 10 years
Meningococcal (dose at age 16 or older) MCV4 (required) **Meningitis B. (recommended)**	____/____/____	**One dose given at age 16 or older**
Varicella (Chickenpox)	#1____/____/____ #2____/____/____ **OR** History of Disease:___Yes ___No Date____/____/____	2 doses varicella **OR** history of disease Minimum of 12 weeks apart if vaccinated between 1 and 12 years of age and at least 4 weeks apart if vaccinated at age 13 years or older
Hepatitis B	#1____/____/____ #2____/____/____ #3____/____/____	3 doses Usual schedule at 0, 1 and 4 months Minimum 4 weeks between doses 1 and 2 Minimum 3 months between doses 2 and 3 Minimum 4 months between dose 1 and 3

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RECOMMENDED IMMUNIZATIONS

RECOMMENDED VACCINES	Dates Given	Recommended Dosing Schedule
Hepatitis A	#1____/____/____ #2____/____/____	Recommended if planning to travel 6-12 months between doses
HPV	#1____/____/____ #2____/____/____ #3____/____/____	Health Care Maintenance
Polio	Primary Series:____Oral ____Injectable Most Recent Booster ____/____/____	Primary Series

_____

Signature of Primary Health Care Provider **Date**

_____

Print Name of Health Care Provider