



UNIVERSITY of WISCONSIN - EAU CLAIRE

Student Health Service • Crest Wellness Center • Eau Claire, WI 54701

Phone: (715) 836-4311 • Fax: (715) 836-5979

Student Immunization Record

To Be Completed From Your Own or Your Physician's Documented Records

Actual Dates of Immunization Are Necessary

Please return completed form to the above address or fax number

Last Name _____ First Name _____ Middle Initial _____ DOB ____/____/____

Student ID # (if known) _____

HEPATITIS B (Three doses of vaccine)

Immunization Dose #1 ____/____/____

Immunization Dose #2 ____/____/____

Immunization Dose #3 ____/____/____

HEPATITIS A (Two doses of vaccine 6 months apart)

Immunization Dose #1 ____/____/____

Immunization Dose #2 ____/____/____

MMR (Measles, Mumps, Rubella) (2 doses required)

Dose #1 age 12-15 months or later ____/____/____

Dose #2 age 4-6 years or later and at least 4 weeks after first dose ____/____/____

TETANUS-DIPHTHERIA (Primary series with DtaP or DPT and a booster dose of Tdap or Td every 10 years)

Dose #1 ____/____/____ Dose #2 ____/____/____

Dose #3 ____/____/____ Dose #4 ____/____/____

Dose #5 ____/____/____

Tdap (Boostrix or Adacel) or Td booster dose every 10 yrs. (circle one if known)

Booster #1 Date ____/____/____

Booster #2 Date ____/____/____

MENINGOCOCCAL (One dose-preferably before entry into college for students living in the residence halls) A choice of 2 different vaccines that each cover 4 of the 5 serotypes.

Menomune or **Menactra** (circle one if known)

Date ____/____/____

POLIO (Primary series in childhood meets requirements:

Dose #1 ____/____/____ Dose #2 ____/____/____

Dose #3 ____/____/____ Dose #4 ____/____/____

VARICELLA (Chicken pox) Either a history of chicken pox disease, a positive Varicella antibody or two doses of vaccine given at least one month apart if immunized after age 13.

History of Disease Date ____/____/____

OR

Reactive Varicella Antibody blood test Date ____/____/____

OR

Immunization..... Dose #1 ____/____/____
Dose #2 ____/____/____

I certify that the above information is a true and accurate statement of the dates on which immunizations were received.

Signature of the student, parent, or health care provider: _____ Date: _____

Medical Exemption

Medical Exemption: the student named above does not have one or more of the immunizations because he/she has:

(check all that may apply and fill in the blanks)

- shown laboratory evidence of immunity against _____ disease(s)
- a medical problem that precludes the _____ vaccine(s)
- had disease _____
- not been immunized because of a history of _____ disease

Physician's signature _____ Date: _____

Conscientious Exemption

Conscientious Exemption: I hereby certify by my signature that immunization against _____ is contrary to my conscientiously held beliefs.

Signature _____

Date: _____