Report of Required Immunization

STUDENT: This form should be returned to Anderson University by Aug. 1 to complete your admissions process.

This requirement must be met in one of two ways. **Indicate your preference by checking one of the two boxes below:**

❑ Have a physician complete this form and return it to you. Then you may return it by mail or deliver to Student Health Services.

❑ You may submit a written request for medical or religious exemption. *(If this box is checked, an exemption form will be sent to you by mail.*

Student's Statement *(to be completed by the student and signed by student and parent/legal guardian)*

STUDENT'S LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____ MAIDEN NAME _____

SSN _____ DATE OF BIRTH _____

All immunizations meet the requirements established by the Indiana State Department of Health and Department of Education. I authorize Anderson University Student Health Services to release this immunization report to the Indiana Department of Public Health or its designated representative, for compliance audits and in the event of a health or safety emergency.

STUDENT'S SIGNATURE _____ DATE _____

PARENT /LEGAL GUARDIAN'S SIGNATURE _____ DATE _____

Physician's Statement

(All live vaccines must have been given after 1969, on or after first birthday.)	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR	MO / DAY / YR
A. **M.M.R. (Measles, Mumps, Rubella):** ***Two doses required.***				
1. Dose 1, given at age 12-15 mos. or later	#1 __/___/___			
2. Dose 2, given at age 4-6 yrs. or later, and at least one month after Dose 1	#2 __/___/___			
B. **Tetanus and Diphtheria:** *Primary series with DTaP or DTP and booster with Tetanus-Diphtheria (Td) or Tdap given within the last 10 years meets requirement.*				
1. Primary series of four doses with DTaP or DTP	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
2. Tetanus-Diphtheria (Td) or Tdap Booster given **within the last 10 years**	#2 __/___/___			
C. **Polio:** *Primary series in childhood meets requirement. Three primary series schedules are acceptable.*				
1. OPV alone (oral Sabin, three doses)	#1 __/___/___	#2 __/___/___	#3 __/___/___	
2. IPV alone (injected Salk, four doses)	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
3. IPV/Opv sequential	#1 __/___/___	#2 __/___/___	#3 __/___/___	#4 __/___/___
D. **Varicella:** *History of chicken pox, positive Varicella antibody, or* ***two doses*** *given at least one month apart after the age 13 yrs. meets requirement.*				
1. History of disease ❑ Yes ❑ No				
2. Varicella antibody ❑ Reactive ❑ Non-Reactive	IPV __/___/___	IPV	OPV	OPV
3. Immunization: a. Dose 1	#1 __/___/___			
b. Dose 2, given at least one month after first dose, if age 13 yrs. or older	#1 __/___/___			
E. **Hepatitis A** ***(Recommended): Two doses*** *or positive surface antibody meets requirement.*				
1. Immunization	#1 __/___/___	#2 __/___/___		
2. Hepatitis A surface antibody ❑ Reactive ❑ Non-Reactive	#1 __/___/___			
E. **Hepatitis B:** ***Three doses*** *or positive surface antibody meets requirement.*				
1. Immunization	#1 __/___/___	#2 __/___/___	#3 __/___/___	
2. Hepatitis B surface antibody ❑ Reactive ❑ Non-Reactive	__/___/___			
F. **Influenza:** *Annual immunization recommended*	__/___/___			
G. **Meningococcal:** *One dose, Quadrivalent polysaccharide vaccine* Immunization (required for students under age 25). Students with immunodeficiency should be vaccinated every 3-5 years. ***Must be current within 5 years.***	__/___/___			

PHYSICIAN'S NAME _____ SIGNATURE _____ DATE _____

STREET ADDRESS _____ CITY _____ STATE _____ ZIP _____ TELEPHONE _____

All records not in English must be accompanied by a certified translation. Please attach a copy of all laboratory results.

2016-17