

CASE WESTERN RESERVE UNIVERSITY
UNIVERSITY HEALTH SERVICE*10900 EUCLID AVE*CLEVELAND OH 44106-4901
(216) 368-2450

IMMUNIZATION RECORD

Please complete both sides of this form and return to the University Health Service.
PLEASE KEEP A COPY OF THIS FORM FOR YOUR OWN RECORDS

PART I: TO BE COMPLETED BY STUDENT

Name _____
Last First M.I.

Address: _____

_____ Date of Enrollment: _____

Date of Birth ____/____/____ Social Security # ____ - ____ - ____ Phone (____) _____
Month Day Year

PART II: TO BE COMPLETED BY A HEALTH CARE PROVIDER OR ATTACH A COPY OF YOUR HIGH SCHOOL IMMUNIZATION RECORD (Dates must include month, day and year.)
REQUIREMENTS ARE RECOMMENDED BY CENTER FOR DISEASE CONTROL AND AMERICAN COLLEGE HEALTH ASSOCIATION.

A. TETANUS-DIPHTHERIA

1. Completed primary series of tetanus-diphtheria immunizations. Date: ____/____/____
Mo Day Yr
2. Received tetanus-diphtheria booster within the last 10 years Date: ____/____/____
Mo Day Yr

TWO DOSES OF MEASLES ARE REQUIRED FOR ALL STUDENTS EXCEPT THOSE BORN BEFORE 1/1/1957

B. M.M.R. (Measles, Mumps, Rubella) If given instead of individual immunizations

1. Dose 1 - Immunized at 12 months or later, and before 5 years Date: ____/____/____
2. Dose 2 - Immunized at 5 years or after Date: ____/____/____

C. MEASLES (RUBEOLA) Check appropriate box

1. Born before 1-1-57 and therefore considered immune Date: ____/____/____
2. Has report of Measles titer. (Attach results) Date: ____/____/____
Specify results of titer: _____
3. Immunized with **LIVE** measles vaccine
Dose 1 - Immunized at 12 months or later, and before 5 years Date: ____/____/____
Dose 2 - Immunized at 5 years or later Date: ____/____/____

D. RUBELLA - Check appropriate box

1. Has report of Rubella titer (Attach results) Date: ____/____/____
Specify results of titer: _____
2. Immunized with vaccine at 12 months or later Date: ____/____/____

E. MUMPS - Check appropriate box

1. Has report of Mumps titer _____ (Attach results) Date: ____/____/____
2. Immunized with vaccine at 12 months or later Date: ____/____/____

NAME _____ SOC.SEC. # _____ - _____ - _____

F. **POLIO**

1. Completed primary series of polio immunization: Yes No
Type of vaccine: oral inactivated E-IPV (Date of Last Booster)Date:..... / /
Mo Day Yr

G. **TUBERCULOSIS** - Check appropriate box. (REQUIRED FOR: Students in the Schools of Dentistry, Nursing, Medicine, MSASS, Ohio College of Podiatric Medicine, the Masters in Anesthesia Program and the Lerner School of Medicine TB Skin Testing will be provided by the University Health Service after you are registered)

1. PPD (Mantoux) (Tine or monovac not acceptable) Specify date given and read .. / / / /
Test Results: Negative Positive mm induration _____ Mo Day Yr Mo Day Yr

If positive, was a Chest x-ray done? Date _____ X-Ray Results: POS NEG

2. If PPD was positive, did you receive treatment with an anti-tuberculosis drug? Yes No

If Yes, specify drug and duration of treatment _____

3. Had BCG Vaccine(bacillus Calmette-Guérin) in the past - specify year. / / /
Test Results: Negative Positive Mo Day Yr

H. **CHICKEN POX**

1. Had disease. Date . / /

2. Received Chicken Pox Vaccine:..... Dose #1: Date / / / Dose #2: Date / / /

3. Varicella titer done - Results: _____ (Attach results) Date. / / /
This is strongly recommended for students in Medicine, Dentistry, OCPM and the Masters in Anesthesia Program who have not had the disease. It is REQUIRED for the students in the Doctor of Nursing Practice and BSN programs.

I. **MENINGOCOCCAL VACCINE**.....Date: / / (Optional for everyone)

J. **HEPATITIS A VACCINE**.....Dose #1: Date: / / / Dose #2: Date: / / / (Optional for everyone)

K. **HEPATITIS B VACCINE** - Name of Vaccine _____

1. Dose #1 Date / / /

2. Dose #2 Date / / /

3. Dose #3 Date / / /

L. **Results of Hepatitis B Serology** (if any)

HBsAg Results: (Antigen) _____ (Attach results) Date: ... / / /

HBsAb Results: (Antibody) _____ (Attach results) Date: ... / / /

Students entering the schools of DENTISTRY, MEDICINE, NURSING, OCPM and the Masters in Anesthesia Program must supply all of the information requested on this form except where indicated as optional. Without this information you may be delayed in starting some clinical activities.

HEALTH CARE PROVIDER INFORMATION:

NAME: _____ ADDRESS: _____

SIGNATURE: _____ PHONE: (_____) _____ DATE _____