

IMMUNIZATION RECORD FORM
Health and Wellness
NOTRE DAME DE NAMUR UNIVERSITY

CONFIDENTIAL INFORMATION

Students must complete and return before moving into the dorms or before the first day of the term if residing off campus:

Health and Wellness

I. All students are subject to immunization requirements upon entry into NDNU.

- All undergraduate students
- All graduate students
- All intensive students

II. Laboratory test showing proof of immunity is acceptable documentation.

College Immunization Requirements:

- 1. Measles: 2 doses**
- 2. Mumps: 1 dose**
- 3. Rubella: 1 dose**
- 4. Tuberculosis (PPD)**

Highly Recommended

- 1. Hepatitis B: 3 doses**
- 2. Hepatitis A: 2 doses**
- 3. TD (Tetanus/Diphtheria) one dose in last ten years**
- 4. Meningococcal Vaccine**
- 5. HPV (females only)**

Please Print

Today's Date _____ Student ID# _____

Last Name _____ First Name _____

Date of Birth _____ Program Major _____

Check one of the categories below and submit verification as indicated. Please sign your name at the bottom of the page.

- 1. I am submitting a copy of my school immunization record that includes all the required immunizations or disease history as listed on the back of this form.
- 2. I am submitting an immunity history signed by a physician or registered nurse verifying all my immunizations, titres or disease history as listed on the back of this form.

Student Signature _____ Date _____

ALL IMMUNIZATION SECTIONS ARE TO BE COMPLETED BY A PHYSICIAN OR REGISTERED NURSE

FOR MEASLES, MUMPS, RUBELLA : Complete section A, or B.

REQUIRED IMMUNIZATIONS

(Complete dates are required.)

A. MMR (Measles, Mumps, Rubella) VACCINES:

#1 Date ___/___/___ and at least one month later #2 Date ___/___/___

OR

B. MEASLES (Rubeola) (a or b)

a. Two doses of live vaccine at least one month apart. Dates #1 ___/___/___ #2 ___/___/___

OR

b. Positive Titre _____:_____ Date ___/___/___

MUMPS (Parotitis) (a or b)

a. Live vaccine Date ___/___/___ **OR** b. Positive titre _____:_____ Date ___/___/___

RUBELLA (German measles) (a or b)

a. Live vaccine Date ___/___/___ **OR** b. Positive titre _____:_____ Date ___/___/___

C. Tuberculosis (PPD test within 1 year of the first day of classes or CXR within the last 2 years for prior positive PPD)

1. PPD (Mantoux) **within 1 year of the first day of classes** Date ___/___/___

Result: _____ mm induration (horizontal diameter).

(OR) Chest x-ray within the past 2 years for prior positive PPD (**copy of chest x-ray report required**) Date ___/___/___

2. If PPD test has greater than 10 mm induration, **attach copy of chest x-ray report**

3. Have you receive treatment for positive TB test? Yes ___ No ___

Date treatment began: _____ Date treatment completed: _____

HIGHLY RECOMMENDED

A. DIPHTHERIA/TETANUS

Any combination of three or more doses of DPT, DT or TD, provided the last dose was administered within the last ten years.

Type _____ Date of latest dose ___/___/___

B. HEPATITIS B: Series of three

1) Date ___/___/___ 2) one month later-Date ___/___/___

3) six months later- Date ___/___/___

OR

Positive titre: _____:_____ Date ___/___/___

C. Hepatitis A: Two doses

1) Date ___/___/___ 2) one month later-Date ___/___/___

D. Meningococcal Vaccine: Date ___/___/___

E. HPV (human papilloma virus): Date ___/___/___

MEDICAL WAIVER

The above-named student has been examined by me. In my opinion the physical condition of the student is such that his/her health will be endangered by any such immunization.

Physician or Registered Nurse Signature _____ RN/MD

Printed name _____ Date ___/___/___

Signed _____ RN/MD Date ___/___/___

NOTE: This original form will become part of the student's permanent record. Please make copies for your future use.