

Immunization Policy

Confidential Information

All incoming and current Residential and International students are subject to immunization requirements upon entry into NDNU. Please complete and return this form **prior to moving in**.

Required Immunizations:

Population	Required Immunizations
Incoming & Current Residential Students	1. MMR (Measles, Mumps, and Rubella), two doses administered at least one month apart _____ 2. Tuberculosis PPD (Mantoux or IGRA) test administered within 6 months before the first day of the semester _____ 3. Hepatitis B (3 doses or completed licensed series)
Incoming & Current International Students	1) Tuberculosis PPD (Mantoux) or Blood Test (IGRA) or Chest X-Ray

Note: Laboratory tests showing proof of immunity is acceptable documentation

Recommended Immunizations: All Students are highly encouraged to consider vaccination of the following diseases:

- Human Papillomavirus (HPV) – females only
- Hepatitis A – 2 doses
- Tetanus – Diphtheria-Pertussis (Tdap) within 10 years
- Varicella (Chicken Pox) – all adults without immunity
- Meningococcal (Meningitis) – strongly recommended for freshman residents
- Polio – especially for international students

Student information:	
Last Name: _____	First name: _____
Student ID: _____	Date of Birth: _____/_____/_____
Program Major: _____	Semester /Year Admitted: _____

Check one of the categories below and submit verification as indicated.

- I am submitting my immunization record that includes all of the required immunizations or disease history.
- I am submitting my immunization history signed by a physician or registered nurse verifying all my immunizations, titers, or disease history.
- My healthcare provider has filled out all immunization dates/titers on this form.

Student Signature: _____ Date: ____/____/____

B. Required Immunizations

To be completed by a healthcare provider unless immunization record is attached.

Measles, Mumps, and Rubella (MMR) Vaccine

Dose #1: (mm/dd/yyyy) ____/____/____ Dose #2: (mm/dd/yyyy) ____/____/____

Measles Titer (mm/dd/yyyy) _____ Result immune NOT immune

Mumps Titer (mm/dd/yyyy) _____ Result immune NOT immune

Rubella Titer (mm/dd/yyyy) _____ Result immune NOT immune

Tuberculosis (PPD) test administered 6 months before the first day of the semester

Date: (mm/dd/yyyy) ____/____/____ Result immune NOT immune

Result: _____ mm induration (horizontal diameter)

(OR) Chest X-Ray within the past 2 years for a prior positive PPD

(Copy of Chest X-Ray Required)

Date: (mm/dd/yyyy) ____/____/____

If you had a positive Chest X-Ray, did you receive treatment? Yes No

Date treatment began: _____ Date treatment completed: _____

Hepatitis B, 3 doses

Dose #1: (mm/dd/yyyy) ____/____/____ Dose #2: (mm/dd/yyyy) ____/____/____

Dose #3: (mm/dd/yyyy) ____/____/____

Positive Titer: _____:_____ Date: (mm/dd/yyyy) ____/____/____

Hepatitis A, 2 doses

Dose #1: (mm/dd/yyyy) ___/___/___

Dose #2: (mm/dd/yyyy) ___/___/___

Tetanus-Diphtheria-Perussis (Tdap) Administered within the last 10 years

Date of the most recent booster dose: (mm/yyyy) ___/____

Type of Booster: _____

Meningococcal (Meningitis) – strongly recommended for freshman residents

Date: (mm/dd/yyyy) ___/___/___

Varicella (Chicken Pox)

History of chicken pox? Yes No

Dose #1: (mm/dd/yyyy) ___/___/___

Dose #2: (mm/dd/yyyy) ___/___/___

Varicella Antibody Titer: Date (mm/yyyy) ___/____

Human Papillomavirus (HPV)

Dose #1: (mm/dd/yyyy) ___/___/___

Dose #2: (mm/dd/yyyy) ___/___/___

Dose #3: (mm/dd/yyyy) ___/___/___

Polio

Dose #1: (mm/dd/yyyy) ___/___/___

Dose #2: (mm/dd/yyyy) ___/___/___

Dose #3: (mm/dd/yyyy) ___/___/___

D. Healthcare Provider Information

Name: _____	Certification: MD / NP / PA/ RN	
Address: _____		
City: _____	State: _____	ZIP: _____
Telephone: (____) _____		
Signature (required) _____	Date: _____	

Return to:

NDNU Health Services
New Hall W01
(O) 650-508-3756
(F) 650-508-3447