Immunization Form

Name: _____

Date of Birth: _____ Phone: _____

Immunization History

	Month/Day/Year	Month/Day/Year	Month/Day/Year
1. MMR (Measles, Mumps, Rubella)			DO NOT WRITE HERE
2. Hepatitis B Series			
3. Meningitis Vaccine			DO NOT WRITE HERE

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	Month/Day/Year	Month/Day/Year	Month/Day/Year
5. Tdap (Tetanus/Diphtheria/Pertussis)		DO NOT WRITE HERE / DO NOT WRITE HERE	
6. Varicella (Chickenpox)			DO NOT WRITE HERE
7. Polio Vaccine			

4. Tuberculosis Screening: if indicated.				
TB Skin Test by PPD (Mantoux)	**Date Placed**	**Date Read**	**MM**	**Neg Pos**
Chest X-ray (if positive PPD)	**Date**	**Result**	***Submit copy of chest X-ray report***	

An authorized signature must appear here or this form will not be approved.

Print Authorized Name of Health Care Provider	Authorized Signature of Health Care Provider	Date

Address	Phone, with area code
_____	_(_____)_____

IMPORTANT! KEEP A COPY OF THIS PAGE FOR YOUR RECORDS.

Mail or return to the Wellness Center prior to first day of classes:

Jamie Kemp MPAS, PA-C
Director of Health Services
Ohio Dominican University
PO Box 307761
Gahanna, Ohio 43230