



Instructions: The form below is to be used as a GUIDE for gathering required immunization information for those Graduate students who will not receive access to the required online forms in the Banner system until Orientation: Graduates School of Arts and Sciences, Masters of Arts in Liberal Studies (MALS), Thayer School of Engineering, and Center for the Evaluative Clinical Sciences (CECS) students ONLY. **All other students please refer to the Health Service Packet for Instructions or go to www.dartmouth.edu/health 'Incoming Student Information' for your respective class links to the online system and forms.)

We request that all students provide us with an authenticated copy of their immunization records in addition to completing the required online forms. These records may be presented in the form of physician signed print-out from a doctors office, yellow card, state health certificate, or other physician-signed documentation. ***This is NOT a required form; it is designed to be a guide only, however should you choose to print and use this form in place of one of the above options, please make sure that it has been signed, dated, and addressed by a physician on the last page before submission.*** Forms submitted without clinician signature will not be accepted.

****THIS FORM DOES NOT TAKE THE PLACE OF THE ONLINE HEALTH AND IMMUNIZATION FORMS WHICH MUST BE COMPLETED BY THE STUDENT WHEN SYSTEM ACCESS HAS BEEN RECEIVED !****

Student Name: _____ **DOB:** _____

1: Measles, Mumps, and Rubella (MMR) [Satisfies Immunization Requirement for Measles, Mumps, and Rubella]

Two doses of MMR are required. Dose one of MMR must be administered after the first birthday and the second given a minimum of four weeks later. Individual shots are also accepted; two doses of measles and mumps must be given at least four weeks apart and one dose of rubella, all administered after the first birthday. A blood test (titer) showing immunity is also acceptable. History of the disease confirmed by your doctor's records is accepted for Measles only. History of disease for Mumps and/or Rubella is not acceptable.

If you have never been immunized for measles, mumps, and/or rubella, you should do so now and then complete this form with your updated immunization information.

Please specify the dates of your MMR immunizations. Two doses are required.

If both MMR vaccinations are complete please proceed directly to #9

Date for Dose 1:

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Date for Dose 2:

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2: Measles [Satisfies Immunization Requirement for Measles]

Individual Measles, Mumps, and Rubella immunizations are an alternative to a combined MMR immunization. If you have received individual immunizations for measles, please indicate the date that each dose was given.

Please specify the dates of your Measles immunizations. Two doses are required.

Date for Dose 1:

Date for Dose 2:

3: Measles Serology [Satisfies Immunization Requirement for Measles]

Please specify the date and result of any blood test (titer) for Measles immunity.

Test Date:

Result: Positive Negative

4: Measles History of Disease[Satisfies Immunization Requirement for Measles]

Please provide the date of measles infection

Date of Infection:

5: Rubella [Satisfies Immunization Requirement for Rubella]

Individual Measles, Mumps, and Rubella immunizations are an alternative to a combined MMR immunization. If you have received an individual immunization for rubella, please indicate the date that the dose was given.

Please specify the date of your Rubella immunization.

Date for Dose 1:

6: Rubella Serology [Satisfies Immunization Requirement for Rubella]

Please specify the date and result of any blood test (titer) for Rubella immunity.

Test Date:

Result: Positive Negative

7: Mumps [Satisfies Immunization Requirement for Mumps]

Individual Measles, Mumps, and Rubella immunizations are an alternative to a combined MMR immunization. If you received individual immunization for mumps, please indicate the date each dose was given.

Please specify the dates of your Mumps immunization. Two doses are required.

Date for Dose 1:

Date for Dose 2:

8: Mumps Serology [Satisfies Immunization Requirement for Mumps]

Please specify the date and result of any blood test (titer) for Mumps immunity.

Test Date:

Result: Positive Negative

9: Tetanus Primary Series [All students must have had the primary series with DTaP or DTP.]

The tetanus primary series is a 4-5 dose series with DTaP or DTP received during early childhood.

Please specify the dates the primary series was given.

Date for Dose 1:

Date for Dose 2:

Date for Dose 3:

Date for Dose 4:

10: Diphtheria and Tetanus (Td or Tdap) Immunizations [Satisfies Immunization Requirement for Tetanus and Diphtheria]

Dartmouth Medical Students please proceed directly to line 11.

All students are required to have received a tetanus/diphtheria booster within the past 10 years. Td or Tdap (see # 11) are acceptable to satisfy this requirement.

If you have not been immunized for tetanus/diphtheria within the past 10 years you should do so now and complete the form with your updated information.

Please specify the date of the tetanus/diphtheria immunization.

Date for Dose 1:

11: Tetanus/diphtheria/pertussis (TDAP) [Satisfies Dartmouth Medical School students Immunization Requirement.]

TDAP is required for all Dartmouth Medical Students. It is also accepted for all other students to satisfy the tetanus/diphtheria requirement above.

Please specify the date of your TDAP immunization.

Date for Dose 1:

12: Menactra [Satisfies Immunization requirement for Meningitis]

All students are required to have received a meningococcal vaccine within the past 5 years.

Please enter the date of any Menactra vaccine received. **Complete this only if you know that Menactra was administered.**

If you have not received a meningococcal vaccine within the past 5 years you should do so now and complete the form with your updated information. Menactra offers life-long immunity to meningitis.

Please specify the date of any meningococcal vaccine received.

Date for Dose 1:

13: Menomune [Satisfies Immunization requirement for Meningitis]

All students are required to have received a Meningococcal vaccine within the past 5 years.

Please enter the date of any Menomune vaccine received. **Complete this only if you know that Menomune was administered.**

If you have not received a meningococcal vaccine within the past 5 years you should do so now and complete the form with your updated information. The Menomune vaccine is medically effective for a 5 year time period.

Please specify the date of any meningococcal vaccine received.

Date for Dose 1:

14: Varicella (Chicken Pox) [Required for ALL Dartmouth Medical School students. Recommended for all other students.]

Varicella immunization or evidence of immunity is a requirement for all Entering Medical School Students.

Varicella immunity may be proven with evidence of two immunizations given at least one month apart, a positive blood test (titer), or disease history confirmed by your doctor's record.

Please specify the dates of your Varicella vaccinations. Two doses are required.

Date for Dose 1:

Date for Dose 2:

15: Varicella Serology [Satisfies Dartmouth Medical School Student Varicella Immunization Requirement]

Please specify the date and result of any blood test (titer) for Varicella immunity.

Test Date:

Result: Positive Negative

16: Varicella (Chicken Pox) History of Disease [Satisfies Dartmouth Medical School students Immunization Requirement for Varicella. Recommended for all others.]

Please provide the date of Varicella infection.

Date of Infection:

18: Hepatitis B [Required for ALL Dartmouth Medical School Students. Recommended for all other students]

Hepatitis B immunization or evidence of immunity is required for all entering Dartmouth Medical School students. Immunity may be provided with proof of a series of vaccinations or by positive immune titer.

If you have not yet started your series it is recommended you do so as soon as possible. Hepatitis B is a 3 vaccine series with dose 2 given no sooner than 30 days after dose 1, and dose 3 no sooner than 5 months after dose 2. If you are unable to complete the series before the start of school, you may receive final vaccinations at the Dartmouth College Health Service.

Please indicate the date that each dose of Hepatitis B vaccine was given. Three doses are required. A fourth dose is only required in the case of a negative immune titer after the original series has been completed.

Date for Dose 1:

Date for Dose 2:

Date for Dose 3:

Date for Dose 4:

19: Hepatitis B Serology [Satisfies Dartmouth Medical School Hepatitis B requirement.]

Please indicate the date and result for any blood test (titer) for Hepatitis B immunity.

Test Date:

Result: Positive Negative

20: PPD (Mantoux test for Tuberculosis) [Required for ALL Dartmouth Medical School students. All others please complete the separate Tuberculosis Screening Form on your Banner page]

A PPD test within the past 12 months is a Dartmouth Medical student requirement.

Please note: If you have had a current or past positive PPD test, please refer to instructions on the Tuberculosis Screening Form (separate).

If you have had a PPD test for Tuberculosis, please record the result here.

1 Date of Administration:

Date Read:

Result: Positive Negative

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21: Polio [Recommended for all students]

If you received the Primary Series for Polio, please indicate the date that each dose was given:

Date for Dose 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 4:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 5:	<input type="text"/>	<input type="text"/>	<input type="text"/>

22: Hepatitis A [Recommended for all students]

Hepatitis A immunizations are not required but are recommended for all students, especially those considering international travel. Hepatitis A is a 2 vaccine series, the second shot to be given no sooner than 6 months after the 1st.

Please indicate the date that each dose of Hepatitis A vaccine was given. Two doses are required for completion of the series.

Date for Dose 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>

23: Pneumococcal Vaccine [Recommended for all students]

Pneumococcal vaccines are recommended for all students with pulmonary disease or immune deficiency.

Please specify the date Pneumococcal dose given

Date for Dose 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
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24: HPV Vaccination [Per CDC guidelines]

Date for Dose 1:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 2:	<input type="text"/>	<input type="text"/>	<input type="text"/>
Date for Dose 3:	<input type="text"/>	<input type="text"/>	<input type="text"/>

Clinical Provider Signature: _____ Date: _____

Address: _____