DAVIDSON COLLEGE

IMMUNIZATION RECORD: To be completed and signed by Healthcare provider or clinic.
A complete immunization record from a physician or clinic may be attached to this form.

Last Name (print above)	First Name	Middle Name	Date of birth (mo./ day /year)	Davidson ID #

SECTION A Required Immunizations	mo./ day/ year	mo./day / year	mo. / day / year	mo. / day / year
• DTaP / DTP (Diphtheria-Tetanus-Pertussis)	#1	#2	#3	#4
• Td (Tetanus-Diphtheria)				
· Tdap (Tetanus-Diphtheria-acellular Pertussis) **BOOSTER** dose within 10 years				
• Polio				
• MMR (After first birthday)				
• Measles (After first birthday)			* Disease Date	*** Titer Date & Result
• Mumps			** (Disease Date Not Accepted)	*** Titer Date & Result
• Rubella			** (Disease Date Not Accepted)	*** Titer Date & Result
• Hepatitis B Series (Required if born 7/1/94 or after) **Blood titer not accepted as proof of immunization.** **OR**	#1	#2	#3	**TITER NOT ACCEPTED**
Heplisav B (2-dose series, given at age 18 years or older) **OR**	#1	#2		**TITER NOT ACCEPTED**
Hepatitis A/B combination series	#1	#2	#3	**TITER NOT ACCEPTED**
• Varicella (chicken pox) At least one dose required if born after **04/01/01**, or immunity by positive blood titer, protective antibody titer or disease date.	#1	#2	Disease Date	*** Titer Date & Result
• Meningococcal (MCV): 2 doses required if born on or after **1/1/03** Only one dose is required if the first dose was given on or after the 16th birthday.	#1	#2		

*Must repeat Rubeola (measles) vaccine if received even one day prior to 12 months of age

** Only laboratory proof of immunity to rubella or mumps is acceptable if the vaccine is not taken. History of rubella or mumps disease , even from a physician is not acceptable.

*** **Copy of laboratory report must be attached for titer results**

CONTINUED ON THE NEXT PAGE FOR OPTIONAL VACCINES AND PROVIDER SIGNATURE

DAVIDSON COLLEGE

IMMUNIZATION RECORD: (PAGE 2)

Last Name (print above)	First Name	Middle Name	Date of birth (mo./ day /year)	Davidson ID #

SECTION B Recommended Immunizations; Not Required	mo./day/year	mo./day/year	mo./day/year	
• Human Papillomavirus (HPV) Vaccine	#1	#2	#3	
• COVID-19 Vaccine Initial Series: Please circle Pfizer, Moderna, Johnson & Johnson Novavax AstraZeneca, Covisheild, Sinopharm, Sinovac, Other_____	#1	#2		
• COVID-19 BOOSTER Please circle Pfizer, Moderna, Johnson & Johnson AstraZeneca, Covishield, Sinopharm, Sinovac • Other _____	#1	#2	#3	#4
• Hepatitis A Series	#1	#2		

SECTION C Optional Immunizations	mo./ day / year	mo./day /year	mo. / day / year
• Typhoid (Specify IM or Oral)			
• Yellow Fever			
• Serogroup B Meningococcal – (Circle Trumemba / Bexera)			
Other:			
Other:			

Signature or Clinic Stamp is REQUIRED:

_____ _____

Signature of Physician/Physician Assistant/Nurse Practitioner Date

_____

Print name of provider above Telephone

_____

Office address City State Zip Code