Last Name: _____ First Name: _____ Date of birth:_____

Swarthmore College Immunization Record

To be completed and signed by a Health Care Professional. All information must be completed in English. You must attach immunization documents printed by your health care provider's office.

The following vaccine information is mandatory:

A. M.M.R. (MEASLES, MUMPS, RUBELLA)
(Two doses requirement at least 28 days apart for students born after 1956)

1. Dose 1 given **after 12 months** of age. . . . . Dose#1_____/_____/_____

2. Dose 2 given **at least 28 days after** first dose . . . . . Dose#2_____/_____/_____

B. TETANUS-DIPHTHERIA-PERTUSSIS
(Primary series with DTaP, DTP, DT, or Td, First Tdap at 11 or 12 years of age or later and booster must be within the last ten years.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:

Dose#1_____/_____/_____, Dose#2_____/_____/_____, Dose#3_____/_____/_____, Dose#4_____/_____/_____ **in addition to Tdap booster below**

2. Booster: within the last ten years

Tdap_____/_____/_____

C. VARICELLA, note 2 dose requirement

Dose#1_____/_____/_____, given **after 12 months** of age

Dose#2_____/_____/_____ given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after the first dose if age 13 years or older

OR

History of Disease Yes_____No_____If so, when? _____ **Health Care Professional signature**:_____

D. MENINGITIS (MenACYW) **(One dose is required at age 16 or older)**

Vaccine **OR** Waiver is required of all Swarthmore College Residence Students
Date of Vaccinations:

Dose#1_____/_____/_____ Dose#2_____/_____/_____

E. MENINGITIS B The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) _____routine _____outbreak-related

Dose #1_____/_____/_____ Dose #2 _____/_____/_____

OR

2. MenB-FHbp (Trumenba)_____routine _____outbreak-related

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

F. COVID-19, the primary vaccine series must be completed with the same vaccine.

1. Johnson & Johnson's Janssen – one dose Dose #1_____/_____/_____
2. Moderna - two doses separated by 28 days Dose #1_____/_____/_____ Dose #2 _____/_____/_____
3. Pfizer-BioNTech - two doses separated by 21 days Dose #1_____/_____/_____ Dose #2 _____/_____/_____
4. Sinopharm-VeroCell – two doses separated by 21 days Dose #1_____/_____/_____ Dose #2 _____/_____/_____
5. AstraZeneca-CoviShield – two doses separated by 8-12 weeks Dose #1_____/_____/_____ Dose #2 _____/_____/_____
6. Sinovac-Coronavac – two doses separated by 14 days Dose #1_____/_____/_____ Dose #2 _____/_____/_____

G. COVID-19 BOOSTER, one dose of either Pfizer or Moderna COVID-19 vaccine is preferred. Alternatively, a Johnson & Johnson Janssen is accepted.
Name of booster vaccine: _____ Date given: _____

(over)

Last Name: _____ First Name: _____ Date of birth:_____

H. HEPATITIS B

1. Immunization (hepatitis B)

Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose#3_____/_____/_____

Adult formulation_____Child formulation_____ Adult formulation_____Child formulation_____ Adult formulation_____Child formulation_____

OR

2. Immunization (Combined hepatitis A and B vaccinc)

Dose #1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

OR

3. Hepatitis B surface antibody

Date_____/_____/_____ **Result**: Reactive_____ Non-reactive_____

I. POLIO (Primary series, doses at least 28 days apart. Three primary series are acceptable See ACIP website for details)

1. OPV alone (oral Sabin three doses) Dose#1_____/_____/_____, Dose#2_____/_____/_____,Dose#3_____/_____/_____

OR

2. IPV/OPV sequential: IPV#1_____/_____/_____,IPV#2_____/_____/_____,OPV#3_____/_____/_____/,OPV#4_____/_____/_____

OR

3. IPV alone (injected Salk four doses: Dose#1_____/_____/_____,Dose#2_____/_____/_____,Dose#3_____/_____/_____,Dose#4_____/_____/_____

J. HEPATITIS A

1. Immunization (hepatitis A)

Dose#1_____/_____/_____, Dose#2_____/_____/_____

2. Immunization (Combined hepatitis A and B vaccine)

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

K. HUMAN PAPILLOMA VIRUS VACCINE (HPV)

Immunization (**indicate which preparation, if known**) **Quadrivalent (HPV4)_____** **9-valent (HPV9)_____**

Dose#1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

L. INFLUENZA (provide date of most recent dose) Dose#1_____/_____/_____

M. OTHER VACCINES IF APPLICABLE:

_____

_____

_____

Health Care Provider

******Please attach all immunization records to this form*

Signature: _____Date: _____

Printed Name: _____

Address: _____ Phone: _____