Dartmouth College Health Service at Dick's House

7 Rope Ferry Road, Hanover NH 03755 P: (603) 646-9404

DUE DATE: June 30, 2023

Immunization Form for Geisel Students

FIRST NAME _____ MI _____ LAST NAME _____ BIRTHDATE (MM/DD/YY) _____

PREFERRED NAME _____ CONTACT EMAIL _____ CONTACT PHONE NUMBER _____

REQUIRED IMMUNIZATIONS

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
Tetanus, Diphtheria, Pertussis Primary Series (DTap, DTP, or DT) 4-5 shot series received in early childhood.	/ /	/ /	/ /	/ / **If applicable date #5:** / /
Tdap Booster (Tetanus, Diphtheria, acellular Pertussis) Dartmouth requires a Tdap on/after age 11. A valid Tetanus shot dated after 9/1/13 is also required. If Tdap was given after age 11 and after 9/1/13 it will meet both requirements.	**( ) International Student: Tdap not available in home country. Vaccine will be received at Dartmouth College.**	/ / **Tdap (Required)**	/ / **dT (If booster is something other than dT, please specify below)** _____	
MMR Vaccine Two doses required (doses must be given at least 28 days apart beginning on or after 12 months of age).	/ /	/ /	**The MMR vaccines may be substituted with 2 Measles, 2 Mumps and 1 Rubella vaccine, OR laboratory evidence of immunity.**	
MEASLES	/ /	/ /	**( ) Titer –Attach Report** / /	
MUMPS	/ /	/ /	**( ) Titer –Attach Report** / /	
RUBELLA	/ /	**( ) Titer –Attach Report** / /		

POLIO PRIMARY SERIES (OPV or IPV) 4-5 shots received in early childhood. IMPORTANT! If polio vaccine has never been administered, please start the IPV series. Three doses of IPV are REQUIRED.	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )	/ / IPV ( ) OPV ( )
VARICELLA -2 Vaccines *OR* Laboratory evidence of immunity REQUIRED. (doses must be given 28 days apart on or after 12 months of age)	/ /	/ /	( ) Varicella Serological Titer *(attach copy of report)*	
Hepatitis B *AND* Quantitative Hepatitis B Surface Antibody Titer REQUIRED **NOTE: If titer is NEGATIVE, please re-start the 2 (if over 18) or 3 shot series immediately, with the first 2 taking place BEFORE you arrive on campus. We can complete the series and repeat titer once on campus** ***(PLEASE SPECIFY TYPE OF VACCINE GIVEN)***	*Hepatitis B series:* / / Repeat Series #1 (If needed) / /	*Hepatitis B series:* / / Repeat Series #2 (If needed) / /	*Hepatitis B series:* / /	( ) Titer –*Attach Report* ( )Positive ( ) Negative

RECOMMENDED VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
COVID 19 Vaccine Primary Series	First / /	Second / /	Manufacturer:	
COVID 19 Primary Booster (5-6 months following Primary Series)	/ /	Manufacturer:		
Additional Covid Booster (Optional)	/ /	Manufacturer:		
Additional Covid Booster (Optional)	/ /	Manufacturer:		
Additional Covid Booster (Optional)	/ /	Manufacturer:		
Additional Covid Booster (Optional)	/ /	Manufacturer:		
Hepatitis A	/ /	/ /		
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Meningococcal ACYW-135	/ /	/ /	/ /	
Meningococcal B	/ /	/ /		
Influenza	/ /	/ /		

OTHER VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
BCG	/ /			
Typhoid Oral ( ) IM ( )	/ /	/ /		
Pneumococcal PCV 13( ) PCV 15 ( )	/ /	/ /	/ /	/ /
Pneumococcal PPSV 23 ( )	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Yellow Fever	/ /			
Japanese Encephalitis	/ /	/ /	/ /	
Jynneos (Orthopox Virus)	/ /	/ /		
Haemophilus Influenza Type B	/ /	/ /	/ /	/ /
Herpes Zoster	/ /	/ /		
PLEASE WRITE IN ANY ADDITIONAL UNLISTED VACCINATIONS BELOW				
Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

Health care provider signature/stamp (REQUIRED):

_____ **(MD / DO / PA / APRN / RN / LPN)** _____

SIGNATURE OF HEALTH CARE PROVIDER DATE

provider/facility stamp here

_____ _____

PRINTED/TYPED NAME OF HEALTH CARE PROVIDER TELEPHONE NUMBER

Health care provider:

1. Please complete this form ensuring patient is in compliance with all 'REQUIRED IMMUNIZATIONS' listed on page 1.
2. Please sign and date the form (above).
3. Please provide patient with the original or a copy of the completed form.

Student:

Please upload your copy of this form and enter vaccine dates into the ONLINE immunization record located on our direct web link: https:\\healthservices.dartmouth.edu

DARTMOUTH COLLEGE
Health Service at Dick Hall's House
7 Rope Ferry Road, Hanover, NH 03755
***Phone*: (603) 646-9404 *Fax*: (603) 646-9410**
Secure Fax: 1-877-884-8110

Student Name:_____Birthdate (MM/DD/YY):_____

If you are an entering Geisel School of Medicine Student you must complete ONE of the following:

- TWO TSTs administered 7-21 days apart (If 1st TST is POSITIVE, please go directly to section B).
- IGRA or QuantiFERON Gold within 6 months of program start (results must be attached and translated into English).
- T-SPOT test within 6 months of program start (results must be attached and translated into English).

Section A- To be completed by healthcare provider (If positive result, proceed to section B)

- **TB testing is required even if you have had the BCG vaccine**
- **A test >10mm is considered positive TB from high prevalence countries, >5mm if you are immunocompromised**

PPD test #1: Date Planted:_____Date Read: _____Induration: _____mm Read within 48-72 hours
PPD test #2: Date Planted:_____Date Read: _____Induration: _____mm Read within 48-72 hours

_____ _____ _____
Signature of Provider MD/PA/APRN/RN Printed Name Date

Section B-To be completed by healthcare provider in the event of positive Tuberculosis test OR history of Tuberculosis.

1. If you have a POSITIVE TST, T-SPOT or IGRA (QuantiFERON Gold); Please complete a CHEST X-RAY
2. Attach a copy of a report for a chest x-ray that was taken upon or after the positive result. This chest x-ray or **MUST** be written or officially translated into English and dated within 6 months of entrance to Dartmouth.
3. Did the student receive tuberculosis therapy? ____**YES** ____**NO**
   a. If yes, please provide the following:
   b. **Start Date**: _____**Completion Date**: _____**Type (Medication):** _____
4. Provide a clinical evaluation. Does the patient exhibit cough, hemoptysis, fever, chills, night sweats or weight loss? Yes____No____If **yes** please describe_____

_____ _____ _____
Signature of Provider MD/PA/APRN/RN Printed Name Date

If you were born in any of the **countries listed below or traveled/lived in any of these countries for more than one month**, you are REQUIRED to submit a Mantoux PPD skin test or a copy of an Interferon gamma release assay (IGRA). The test must have been performed within six months prior to your Dartmouth registration date.
Source: World Health Organization Global Tuberculosis Report 2021

https://www.who.int/news/item/17-06-2021-who-releases-new-global-lists-of-high-burden-countries-for-tb-hiv-associated-tb-and-drug-resistant-tb

ANGOLA
AZERBAIJAN
BANGLADESH
BELARUS
BOTSWANA
BRAZIL
CAMEROON
CENTRAL AFRICAN REPUBLIC
CHAD
CHINA
CONGO
DEMOCRATIC PEOPLE'S REPUBLIC OF KOREA
DEMOCRATIC REPUBLIC OF THE CONGO
ETHIOPIA
GHANA
GUINEA-BISSAU
INDIA
INDONESIA
KAZAKHSTAN
KENYA
KYRGYZSTAN
LESOTHO
LIBERIA
MALAWI
MOZAMBIQUE
MYANMAR
NAMIBIA
NIGERIA
PAKISTAN
PAPUA NEW GUINEA
PERU
PHILIPPINES
REPUBLIC OF MOLDOVA
RUSSIAN FEDERATION
SOMALIA
SOUTH AFRICA
SWAZILAND
TAJIKISTAN
THAILAND
UGANDA
UKRAINE
UNITED REPUBLIC OF TANZANIA
UZBEKISTAN
VIETNAM
ZAMBIA
ZIMBABWE