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 GRADUATE 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.	/ /	/ /	/ /	
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, medically documented proof of disease OR laboratory evidence of immunity.**	
MEASLES	/ /	/ /	**( ) Titer –Attach Report** / /	
MUMPS	/ /	/ /	**( ) Titer –Attach Report** / /	
RUBELLA	/ /	**( ) Titer –Attach Report** / /		
VARICELLA Health care provider documented incidence of disease OR two doses of vaccine OR positive titer.NO PROOF IS NEEDED IF BORN IN THE USA PRIOR TO 1980 (Vaccine doses must be given at least 28 days apart on or after 12 months of age)	/ /	/ /	**Verified Date of Disease** / /	**( ) Positive Titer-** ***Attach Report***

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:		
Additional Covid Booster (Optional)	/ /	Manufacturer:		
Hepatitis A	/ /	/ /		
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /	
Polio Primary Series (OPV or IPV) 4-5 shots in early childhood	/ /	/ /	/ /	/ /
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 PPSV23 ( )	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Yellow Fever	/ /			
Japanese Encephalitis	/ /	/ /	/ /	
Jynneos (Orthopox Virus)	/ /	/ /		
Haemophilus Influenza Type B	/ /	/ /	/ /	/ /
Herpes Zoster	/ /	/ /		
Meningococcal ACYW-135	/ /	/ /		
Meningococcal B	/ /	/ /		
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

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

Instructions:

Health care provider:

1. Please complete this form to ensure the patient is in compliance with all 'REQUIRED IMMUNIZATIONS'.
2. Please sign and date the form (above).
3. Please provide the 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
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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):_____

Section A-To be completed by student

1. Were you born in any of the countries listed on **page 2**? ___**YES** ___**NO**
2. Have you lived or traveled for more than 1 month in any countries on **page 2**? ___**YES** ___**NO**
3. Have you worked, volunteered, or lived in potentially high risk setting such as prison, a long-term care facility, a homeless shelter, residential facility, drug treatment center, or lived with persons with HIV/AIDS? ___**YES** ___**NO**
4. Have you had recent or prolonged contact with someone with **infectious or active** Tuberculosis? ___**YES** ___**NO**
5. Do you have history of a positive TB test? **(If yes proceed directly to section C)** ___**YES** ___**NO**

If you answered "YES" to any of these questions you are required to submit a Mantoux 5TU PPD skin test **OR** an Interferon Gamma Release Assay (IGRA). The test MUST have been performed within 6 months prior to entrance to Dartmouth College. Have your health care provider complete and sign Section B.

If you answered "NO" to all questions, **NO FURTHER ACTION IS REQUIRED**. Please sign and submit this form to the Medical Records Office.

STUDENT SIGNATURE:_____DATE:_____
(By signing I attest the above information is true to the best of my knowledge)

Section B- To be completed by health care provider (If positive result, proceed to section C)

- **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: Date Planted:_____Date Read: _____Induration: _____mm **Read within 48-72 hours**
OR
IGRA Results- (must be written or translated into English): Positive:____Negative: ____Type:_____Date:_____ ***(LAB REPORT MUST BE ATTACHED)***

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

1. If Positive TST, T-SPOT or IGRA (Quantiferon Gold) Please complete 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** , If yes please provide the following:
   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