Dartmouth College Health Service at Dick's House

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

DUE DATE: June 30, 2024

Immunization Form for Geisel Students

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

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
Most Recent COVID Booster	/ /		Manufacturer:	
Hepatitis A	/ /	/ /		
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Meningococcal B	/ /	/ /		
Most Recent 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 ( ) PPSV23 ( )	/ /	/ /	/ /	/ /
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:

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

2. Upload your immunization record or a completed copy of this form to the ONLINE student health portal. For questions please email: Medical.records.for.student.health@dartmouth.edu

3. **Both steps #1 and #2 are REQUIRED. You must enter immunization dates online AND submit a copy of this form to us.**