

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 GRADUATE STUDENTS

FIRST NAME	MI	LAST NAME	BIRTHDATE (MM/DD/YY)
CONTACT EMAIL		CONTACT PHONE NUMBER	

REQUIRED IMMUNIZATIONS

Vaccination	Date 1: 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
Most Recent COVID Vaccination Booster	/ /		Manufacturer:	
Hepatitis A	/ /	/ /		
HPV4 (), HPV9 ()	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /	
Polio Primary Series (OPV or IPV) 4-5 shots in early childhood	/ /	/ /	/ /	/ /
Meningococcal ACYW-135	/ /	/ /		
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	/ /	/ /		
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /
	/ /	/ /	/ /	/ /

Health care provider signature/stamp (REQUIRED):

_____ (MD / DO / PA / APRN / RN / LPN)	_____
SIGNATURE OF HEALTH CARE PROVIDER	DATE
_____	_____
PRINTED/TYPED NAME OF HEALTH CARE PROVIDER	TELEPHONE NUMBER

provider/facility stamp here

Instructions:

Health care provider:

1. Please complete this form ensuring patient is in compliance with all 'REQUIRED IMMUNIZATIONS'.
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.**