Dartmouth College Health Service at Dick's House

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

DUE DATE: June 30, 2021

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 9/1/11 is also required. If TDaP was given after age 11 and after 9/1/11 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	/ /	/ /		
MUMPS	/ /	/ /		
RUBELLA	/ /			
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**
Covid 19 Vaccine	/ /	/ /	**MANUFACTURER:_____**	

OTHER VACCINATIONS (NOT REQUIRED)

Vaccination	Date1: Month/Day/Yr	Date 2: Month/Day/Yr	Date 3: Month/Date/Yr	Date 4: Month/Date/Yr
HPV4 ( ), HPV9 ( )	/ /	/ /	/ /	
Meningococcal ACYW-135	/ /	/ /		
Meningococcal B	/ /	/ /		
Typhoid	/ /	/ /		
Pneumococcal	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Japanese Encephalitis	/ /	/ /	/ /	
Yellow Fever	/ /			

Health care provider signature/stamp (REQUIRED):

_____**(MD / DO / PA / NP / 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 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. Mail your immunization record (or a copy) to Dartmouth College Health Services, ATTN: Medical Records, 7 Rope Ferry Road, Hanover, NH 03755.
3. **Both steps #1 and #2 are REQUIRED. You must enter immunization dates online AND submit a copy of this form to us.**