Dartmouth College Health Service at Dick's House

7 Rope Ferry Road, Hanover NH 03755 P: (603) 646-9400

DUE DATE: June 30, 2022

Immunization Form for Geisel Students

Instructions:

Student:

1. Use this form to enter vaccine dates into the ONLINE immunization record located on our portal at: https:\\healthservices.dartmouth.edu
2. Upload this form and attachments using the "Immunization Upload" button once you are in the portal.
3. **You must enter immunization dates online AND submit a copy of this form to us.**

Health care provider:

1. Please complete this form to ensure patient is compliant with all Dartmouth College, required immunizations.
2. Please sign and date.
3. Please provide patient with the original of the completed form.

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 9/1/12 is also required. If TDaP was given after age 11 and after 9/1/12 it will meet both requirements.	**( ) International Student: Tdap not available in home country. Vaccine will be received at Dartmouth College.**	/ / **Tdap (Required)**	/ / **dT (please specify type of booster)** _____	
MMR Vaccine 2 doses OR 2 Measles, 2 Mumps and 1 Rubella vaccine (doses must be given at least 28 days apart beginning on or after age 12 months), OR laboratory evidence of immunity.	/ /	/ /	**Serological Titer (*attach copy of all reports*)** **( ) Measles** **( ) Mumps** **( ) Rubella**	
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 Primary Series **Booster (5-6 months after Series)**	**First** / / / /	**Second** / /	**Manufacturer:** **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 (REQUIRED):

_____**(MD / DO / PA / NP / RN / LPN)** _____
SIGNATURE OF HEALTH CARE PROVIDER DATE

provider/facility stamp here

_____ _____
PRINTED NAME OF HEALTH CARE PROVIDER TELEPHONE NUMBER