Dartmouth College Health Service at Dick's House

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

DUE DATE: June 30, 2020

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.	/ /	/ /	/ /	/ / **If applicable date #5:** / /
Tdap Booster (Tetanus, Diphtheria, acellular Pertussis) Dartmouth requires a Tdap on/after age 11. A valid Tetanus shot dated after 9/1/10 is also required. If TDaP was given after age 11 and after 9/1/10 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	/ /	/ /		
MUMPS	/ /	/ /		
RUBELLA	/ /			
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***

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 ( )	/ /	/ /	/ /	
Hepatitis B	/ /	/ /	/ /	
Polio Primary Series (OPV or IPV) 4-5 shots in early childhood	/ /	/ /	/ /	/ /
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'.
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.**