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 Undergraduate 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 through the portal.**

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 (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)* 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 Health care provider documented incidence of disease OR two doses of vaccine OR positive titer *(doses must be given at least 28 days apart beginning on or after 12 months of age).*	**/ /**	**/ /**	**Verified Date of Disease** **/ /**	**( ) Positive Titer- *Attach Report***
Hepatitis B (3 vaccines OR positive titer REQUIRED) ***2 dose series (Heplisav) allowed if over 18. *****	**/ /** ***/ /**	**/ /** ***/ /**	**/ /**	**( ) Positive Titer-Attach Report**
QUADRIVALENT MENINGOCOCCAL CONJUGATE ACYW-135 **If initial dose administered prior to age 16, booster dose given at age 16 or older is REQUIRED even if 2 or more doses have been received. If initial dose administered at age 16 or older, booster dose is not required.**	**Indicate Type:** **_____** **/ /**	**/ /**		

Covid 19 Vaccine Primary Series	**First** **/ /**	**Second** **/ /**	**Manufacturer:**
Booster (5-6 months after Series)	**/ /**		**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 B	/ /	/ /		
Typhoid	/ /	/ /		
Pneumococcal	/ /	/ /	/ /	/ /
Rabies	/ /	/ /	/ /	/ /
Japanese Encephalitis	/ /	/ /	/ /	
Hepatitis A	/ /	/ /		
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