MANDATORY PHARMACY STUDENT IMMUNIZATION HISTORY

Please complete with your health care provider and return in the enclosed envelope before you arrive on campus. You may attach additional immunization information from other schools or medical offices. Responses must be in English.

Student Information
Name: __________________________________________  Student ID#: __________________________________________
Email: __________________________________________  Phone: __________________________________________

MEASLES (RUBEOLA)
☐ Immunity confirmed by Titer.
Results __________________________________________  Date of Titer ________________________________
Date of re-immunization: __________________________
Attach copy of lab report

MUMPS
☐ Immunity confirmed by Titer.
Results __________________________________________  Date of Titer ________________________________
Date of re-immunization: __________________________
Attach copy of lab report

GERMAN MEASLES (RUBELLA)
☐ Immunity confirmed by Titer.
Results __________________________________________  Date of Titer ________________________________
Date of re-immunization: __________________________
Attach copy of lab report

TETANUS AND DIPHTHERIA
TD or DT or Tdap required (Tentanus toxoid (TT) not acceptable). Three primary series immunizations are needed OR date of last booster OR exempt status conferred. Please fill in the relevant portion below.

☐ Immunization 1 – Date ______________________________
☐ Immunization 2 – Date ______________________________
☐ Immunization 3 – Date ______________________________
OR
☐ Last Booster Shot – Date ___________________________ (Booster must be within last 10 years)
OR
☐ Exempt Status, Date of exemption ______________________ (Attach physician’s statement)

POLIO
Three immunizations are needed OR date of last booster OR date of immunization as an adult. Please fill in the relevant portion below.

☐ Immunization 1 – Date ______________________________
☐ Immunization 2 – Date ______________________________
☐ Immunization 3 – Date ______________________________
OR
☐ Last Booster Shot Date _____________________________  ☐ Oral (Sabin)  ☐ Injection (Salk)
OR
Immunized as an Adult. Date conferred __________________

--over--
TUBERCULOSIS (Check the appropriate box)

☐ HAS HAD THE DISEASE ☐ HAS NOT HAD THE DISEASE

AND fill out the appropriate section below for annual updates: NOTE: TUBERCULIN SKIN TEST (TST) 2 STEP MAY BE REQUIRED. TST READING MUST BE DONE FROM 48 HOURS AFTER APPLICATION.

☐ TST Step 1 Date read _________________________ Result _________________________ mm induration

☐ TST Step 2 Date read _________________________ Result _________________________ mm induration

OR

☐ Had a positive Mantoux skin test. Year of skin test __________ Attach documentation results and copy of chest x-ray report.

Baseline Chest X-Ray Date ________________________ ☐ Positive ☐ Negative

☐ Had BCG vaccine. Date ________________________

HEPATITIS B Three immunizations are needed AND the documentation of immunity by titer. Please fill in the relevant portion below.

☐ Immunization 1 – Date _________________________

☐ Immunization 2 – Date _________________________

☐ Immunization 3 – Date _________________________

AND

☐ Immunity confirmed by Titer. Date of Titer _________________________

    HB surface antigen ☐ Positive ☐ Negative

    HB surface antibody ☐ Positive ☐ Negative

Antibody must be positive. If the antibody titer is negative, the antigen is required. Repeat immunization may be required under certain circumstances. Attach copy of lab report.

VARICELLA ZOSTER (CHICKEN POX)

☐ Immunity confirmed by Titer. Date of Titer _________________________

Results _________________________ Date of re-immunization: _________________________

Attach copy of lab report

CERTIFICATION BY HEALTH CARE PROFESSIONAL

Name _______________________________________ (circle one) RN  MD  DO  RPH

Name and address of institution or clinic (or stamp)

Phone _________________________ FAX _________________________

I certify that this information is complete and correct to the best of my knowledge.

Signature of Health Care Provider _________________________ Date _________________________

NPI Number _________________________