



AFFIX LABEL HERE or complete the following:

LAST NAME	FIRST NAME	MIDDLE INITIAL
ADDRESS		
HIGH SCHOOL/COLLEGE	PHONE	
BIRTH DATE	MAJOR	CLASS YEAR
FIRST-YEAR / TRANSFER	SMC ID#	

DUE: 07/01/11

Immunization Record

PLEASE RETURN THIS FORM AS SOON AS POSSIBLE, BUT NO LATER THAN JULY 1, 2011, TO:

Student Health Services, Saint Michael's College, One Winooski Park, Box 259, Colchester, Vermont 05439

Ph: 802.654.2234 • Fax: 802.654.2699

This form should be completed by your health care provider.

VACCINES	DATES GIVEN	REQUIREMENTS
Tdap or Td (Tetanus)	Tdap ___ Td ___ #1 ___/___/___	1 Tdap/Td booster within last 10 years (Tdap preferred)
MMR	#1 ___/___/___ #2 ___/___/___ OR Positive Titer Dates: ___/___/___ ___/___/___ ___/___/___ Measles Mumps Rubella	2 doses or positive titers Minimum of 4 weeks between doses 1st dose given after 1st birthday
Bacterial Meningitis	#1 ___/___/___	One dose given within 5 years for students living campus-based housing
Varicella (Chicken Pox)	1. History of disease: Yes ___ No ___ (if no proceed to #2) 2. Immunization: #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___	2 doses of varicella vaccine or history of disease or positive titer Minimum of 4 weeks between doses if age or older (12 weeks for under age 13)
Hepatitis B	#1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___	3 doses or positive titer Minimum of 4 weeks between doses 1 and 2 Minimum of 8 weeks between doses 2 and 3 (3rd dose must be 16 weeks from first dose)

Health Care Provider Information:

Name: _____

Signature: _____

Address: _____

Phone: (_____) _____