

# SEATTLE UNIVERSITY

## IMMUNIZATION RECORD VERIFICATION BY A HEALTH CARE PROFESSIONAL

*(This form is NOT required if you have documentation of required immunizations which can be uploaded directly to the patient portal. Forms must be in English or translated to English to be verified compliant)*

### PART I

Name \_\_\_\_\_  
Last Name First Name  
Address \_\_\_\_\_  
Street City State Zip Code  
Date of Entry     /    /     Date of Birth     /    /     School ID# \_\_\_\_\_  
M Y M D Y

### PART II - TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

#### REQUIRED IMMUNIZATIONS

##### COVID-19 VACCINE - REQUIRED OF ALL STUDENTS

Dose # 1 Vaccine name/Manufacturer: \_\_\_\_\_     /    /      
M D Y  
Dose # 2 Vaccine name/Manufacturer: \_\_\_\_\_     /    /      
M D Y  
Dose #3/Booster Vaccine name/Manufacturer: \_\_\_\_\_     /    /      
M D Y  
Dose #4/Booster Vaccine name/Manufacturer: \_\_\_\_\_     /    /      
M D Y

##### MEASLES VACCINATION - REQUIRED OF UNDERGRADUATE STUDENTS ONLY

(Two doses required at least 28 days apart for students born after 1956 and all health care professional students.)

Dose # 1 (given at age 12-15 months or later)     /    /      
M D Y  
Vaccine given:  MMR  MMRV  ME  MM  MR

Dose # 2 (given at age 4-6 years or later, and at least one month after first dose)     /    /      
M D Y  
Vaccine given:  MMR  MMRV  ME  MM  MR

#### OR

Measles surface antibody  Reactive (positive)  Non-reactive (negative)     /    /      
M D Y

### HEALTH CARE PROVIDER

\_\_\_\_\_  
Name and title of Health care Practitioner

\_\_\_\_\_  
Health care Practitioner's signature

\_\_\_\_\_  
Date signed

\_\_\_\_\_  
Address:

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

**PART III: OPTIONAL**

**RECOMMENDED IMMUNIZATIONS** (recommended by the Advisory Committee on Immunization Practices and the American College Health Association. **NOT REQUIRED.**

**1. TETANUS, DIPHTHERIA, WITH OR WITHOUT PERTUSSIS**

Primary series completed?  Yes  No Date of last dose in series:     /    /      
M D Y

Date of most recent booster:     /    /     Type of booster:  Td  Tdap  
M D Y

Tdap booster recommended for ages 11 – 64 unless contraindicated.

**2. HEPATITIS B** (All college and health care professional students. Three doses of vaccine or a positive hepatitis B surface antibody meets the requirement.)

A. Immunization

#1     /    /     #2     /    /     #3     /    /      
M D Y M D Y M D Y

**OR**

B. Hepatitis B surface antibody  Reactive (positive)  Non-reactive (negative)     /    /      
M D Y

**3. HEPATITIS A**

A. Immunization

#1     /    /     #2     /    /      
M D Y M D Y

**4. POLIO** (Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

A. OPV alone (oral Sabin three doses):..... #1     /    /     #2     /    /     #3     /    /      
M D Y M D Y M D Y

**OR**

B. IPV alone (injected Salk four doses):.....#1     /    /     #2     /    /     #3     /    /     #4     /    /      
M D Y M D Y M D Y M D Y

**OR**

C. IPV/OPV sequential:.....IPV #1     /    /     IPV #2     /    /     OPV #3     /    /     OPV #4     /    /      
M D Y M D Y M D Y M D Y

**5. VARICELLA (Chicken Pox)** (History of chicken pox, a positive varicella antibody, or two doses of vaccine)

A. Immunization

#1     /    /     #2     /    /     (at least 12 weeks after first dose if ages 1-12 y.o.  
M D Y M D Y and at least 4 weeks after first dose if age 13 or older)

**OR**

B. Varicella antibody  Reactive (positive)  Non-reactive (negative)     /    /      
M D Y

C. History of disease     /    /      
M D Y

**6. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)** One dose or 2 doses for all college students – revaccinate every 5 years if increased risk continues.

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible)

#1    /   /     
M D Y                      #2    /   /     
M D Y

**OR**

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available)

Date    /   /     
M D Y

**7. MENINGOCOCCAL SEROGROUP B** (Two or three dose series; may be given to any college student or for outbreak control)

1. MenB-RC (Bexsero)

#1    /   /                         #2    /   /     
M D Y                                      M D Y

**OR**

2. MenB-FHbp (Trumenba)

#1    /   /                         #2    /   /                         #3 (if needed)    /   /     
M D Y                                      M D Y                                      M D Y

**8. INFLUENZA**

Date of last dose:    /   /     
M D Y

**9. PNEUMOCOCCAL POLYSACCHARIDE VACCINE** (One dose for members of high-risk groups)

PCV 13                      Date    /   /     
M D Y

PPSV 23                      Date    /   /     
M D Y

**10. HUMAN PAPILOMA VIRUS** (three doses of vaccine)

#1    /   /                         #2    /   /                         #3    /   /     
M D Y                                      M D Y                                      M D Y

Vaccine given:     Gardasil 4 (HPV4)     Gardasil 9 (HPV9)     Cervarix (HPV2)

**HEALTH CARE PROVIDER**

\_\_\_\_\_  
*Name and title of Health care Practitioner*

\_\_\_\_\_  
*Health care Practitioner's signature*

\_\_\_\_\_  
*Date signed*