VMI IMMUNIZATION RECORD

******This form must be *completed* and signed by the applicant's health care provider.******

Applicant's Name: _____ Date of Birth: ___/___/___

REQUIRED: The following immunizations are required for enrollment at VMI.

1. Diphtheria-Tetanus (DTP): **(Mandatory)**
   Date of completion of childhood series ___/___/___

2. Hepatitis B: **(Mandatory)**
   Date of 1st dose ___/___/___
   Date of 2nd dose ___/___/___
   Date of 3rd dose ___/___/___

3. Meningococcal Quadrivalent Vaccine (MCV4/ACWY): **(Mandatory - One dose after age 16 required)**
   Date ___/___/___

4. Measles-Mumps-Rubella (MMR): **(Mandatory)**
   TWO IMMUNIZATIONS REQUIRED. THE FIRST ONE AFTER THE FIRST BIRTHDAY; THE SECOND ONE NO SOONER THAN ONE MONTH LATER OR ANY TIME THEREAFTER.
   Date of 1st dose ___/___/___
   Date of 2nd dose ___/___/___

5. Poliomyelitis: **(Mandatory)**
   Date of completion of primary series ___/___/___

6. Tdap Booster: **(Mandatory)**
   Date of last booster___/___/___ **(Must be within 10 years of matriculation)**

7. Chicken Pox (had disease) Yes___No___ or Immunization Dates Date of 1st dose ___/___/___
   (2 Doses are mandatory if no disease) Date of 2nd dose___/___/___

8. Tuberculin Test: **(Required for applicants who have lived or traveled extensively overseas)**
   Date ___/___/___ Result: (mm induration: _____)
   CHEST XRAY RESULTS: (only if POSITIVE) _____
   Treatment? _____

RECOMMENDED: The following immunizations are recommended.
If you have not had these vaccines, ask your provider why.

Hepatitis A (Recommended)
Date of 1st dose ___/___/___
Date of 2nd dose ___/___/___

HPV (HUMAN PAPILLOMAVIRUS VACCINE) (Highly Recommended)
Applicant had the □ 2 dose OR □ 3 dose series
Date of 1st dose ___/___/___
Date of 2nd dose ___/___/___
Date of 3rd dose ___/___/___

Meningococcal B (Optional) Discuss with your provider
Applicant had the □ 2 dose **OR** □ 3 dose series
Date of 1st dose ___/___/___
Date of 2nd dose ___/___/___
Date of 3rd dose ___/___/___

_____
Health Care Provider's Signature

_____
Printed Name

_____
City, State Zip Code

_____ _____
Date Area Code & Phone Number