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 Vaccine (MCV4/ACWY)(Menactra/Menveo): **(Mandatory - One dose after age 16 required)**

   Date of 1st dose____/___/____Date of 2nd dose_____/___/____

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___/___/____

9. 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.

COVID-19 (Highly Recommended)

Indicate which vaccine ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other specify_____
Date of 1st dose____/___/___ Date of 2nd dose___/__/___ Date of Booster___/__/___

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) (Bexsero) 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

_____
Area Code & Phone Number

_____
Date