IMMUNIZATION RECORD

Pacific Union College

Return this form to:
Pacific Union College
Health Services
One Angwin Avenue
Angwin, CA 94508
Attn: Health Services

Phone (707) 965-6339
Fax (707) 965-6243

PART I

Name _____ _____
First Name Middle Name

_____
Last Name

Address _____
Street City State Zip

Date of Entry ____/_____ Date of Birth ____/____/_____ School ID# _____
M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate ☐ Professional _____

PART II

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . ..... #1 ____/____/_____
M D Y

2. Dose 2 given at least 28 days after first dose . ..... #2 ____/____/_____
M D Y

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

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

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/_____
M D Y

C. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) ____routine ____outbreak – related

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____
M D Y M D Y

OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related

a. Dose #1 ____/____/_____ b. Dose #2 ____/____/_____ c. Dose #3 ____/____/_____
M D Y M D Y M D Y

D. TETANUS, DIPHTHERIA, PERTUSSIS

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

2. Date of most recent booster dose: ___/___/_____ Type of booster: Td _____ Tdap _____
M D Y

E. INFLUENZA

Trivalent (IIV3) _____ Quadrivalent (IIV4) _____ Recombinant (RIV4) _____ Live attenuated influenza vaccine (LAIV) _____

Adjuvanted inactivated influenza (aIIV3) _____

Date of last dose: ____/____/_____
M D Y

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F. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

G. HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ (M D Y)
   Adult formulation ___ Child formulation ____
   HepB-CpG (Heplisav-B) ____

   b. Dose #2 ____/____/_____ (M D Y)
   Adult formulation ____ Child formulation ____
   HepB-CpG (Heplisav-B) ____

   c. Dose #3 ____/____/_____ (M D Y)
   Adult formulation ____ Child formulation ____
   HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

H. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) Quadrivalent (HPV4) ____ or Bivalent (HPV2) ____ or 9-valent (HPV9) ____

a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

I. VARICELLA

1. Immunization

   a. Dose #1 . ..... #1 ____/____/_____ (M D Y)

   b. Dose #2 given at least 12 weeks after first dose ages 1–12 years. ..... #2 ____/____/_____ (M D Y)
   and at least 4 weeks after first dose if age 13 years or older.

2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

J. PNEUMOCOCCAL POLYSACCHARIDE VACCINE

PCV 13 _____ Date ____/____/_____ (M D Y) PPSV 23 _____ Date ____/____/_____ (M D Y)

K. POLIO

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

2. IPV/OPV sequential: IPV #1 ____/____/_____ (M D Y) IPV #2 ____/____/_____ (M D Y) OPV #3 ____/____/_____ (M D Y) OPV #4 ____/____/_____ (M D Y)

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

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

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