IMMUNIZATION STATUS (Important, please read carefully) To all incoming students: A complete report of your Immunization status is **mandatory** in order to register at Whitworth. This policy is in place for the protection of the university community. University students are at greater risk for contracting a variety of diseases. If you do not have recommended protection during an outbreak, you would be asked to leave campus. The vaccines listed below are recommended by the ACIP (American Counsel on Immunization Practices) www.cdc.gov/nip/ACIP/default.htm and ACHA (American University Health Association) www.acha.org for all students.

NAME:____ **BIRTHDATE**__________ **AGE**______ **Sex**______
(Last) (First) (Middle Initial)

SPORT:____

IMMUNIZATION RECORD: This record becomes part of your permanent medical chart and will be updated with any vaccines received at the Health Center. *Starred vaccines are available at Whitworth Health Center.

Childhood DPT series of 4. (Diphtheria, Pertussis, Tetanus) and 10 year booster of Tetanus and Diphtheria
(DPT) Yes____ No____ Year Completed_________ Last Tetanus Diphtheria Booster Td ___________
(Month/Yr)
(If more than ***ten years***, it is time for another booster. For Health Sciences Students Tdap, one time only 2 to 5 years after last Td.)
Booster ________ Td* ________ Tdap*
(Month/Yr.) (Month/Yr.)

Childhood Oral Polio series of 3 or 4 depending upon type IPV or OPV
Oral Polio, Original Series Yes______ No_____ Year Completed ___________

M.M.R. measles mumps and rubella
(MMR) #1__________ Dose 1 given at 12months or later ; #2__________ Dose 2 given at least 28 days after 1st dose
(Month/Yr.) (Month/Yr.)

Varicella (Chicken Pox) (Birthin the U.S. before 1980, a history of chicken pox, or two doses of vaccine meet the requirement.)
Varicella Immunization #1___________ #2____________ (series of 2)
(Month/Yr.) (Month/Yr.)
History of disease Yes_____ No______ Born in U.S. before 1980 _____ Yes ______ No

Hepatitis A & B *
Hepatitis A series #1__________ #2__________ (series of 2 if given alone)
(Month/Yr.) (Month/Yr.)
Hepatitis B series #1___________ #2___________ #3__________ (series of 3)
(Month/Yr.) (Month/Yr.) (Month/Yr.)
Hepatitis A & B combined vaccine #1___________ #2___________ #3___________ (series of 3)
(Month/Yr.) (Month/Yr.) (Month/Yr.)

Bacterial Meningitis*
Meningococcal Tetravalent Vaccine _____________ (See ACIP guidelines)
(Month/Yr.)

Influenza Vaccination* Yearly __________ __________ ___________ __________
(Month/Yr.) (Month/Yr.) (Month/Yr.) (Month/Yr.)

Human Papillomavirus HPV*
Quadrivalent HPV Vaccine Three doses series for females age 11-26 years at 0,2, 6 months
#1 __________ #2 ___________ #3__________
(Month/Yr.) (Month/Yr.) (Month/Yr.)

Tuberculosis test (PPD) within the last year *
Required if the student is a member of a high risk group** or is entering the health professions.
Most recent tuberculosis test (PPD) Date___________ Results_______
If you had a positive PPD , chest x-ray results ________________ Did you receive INH Therapy? Yes_____ No_____
****Go to http://www.whitworth.edu/Administration/Health&CounselingCenter/Immunization.htm for high risk criteria.

Pneumonia
Pneumococcal Polysaccharide Vaccine (one dose for members of high risk groups) #1 ____________

I CERTIFY THAT THE ABOVE INFORMATION IS CORRECT

____
(Student's Signature) (Date)

If you wish to claim exemption to immunization law please email healthcenter@whitworth.edu and we will email you a copy of the form.
THANK YOU FOR YOUR HELP IN THIS VERY IMPORTANT PERSONAL AND PUBLIC HEALTH ISSUE.