Vaccination Report

Drury University, in compliance with the American College Health Association Immunization guidelines, requires each student to have completed the following vaccinations to ensure the safety of everyone on our campus. **Students are encouraged to complete Part I of this form and attach a photocopy of their vaccination record in lieu of completing Part II.**

To keep students current with their immunizations while on campus, the following vaccines are available at a reduced fee from the Panther Clinic: Td, Tdap, and the seasonal Influenza vaccine.

**PART I**

<table>
<thead>
<tr>
<th>Name ___________________________________________________</th>
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<tbody>
<tr>
<td>First Name</td>
<td>Middle Name</td>
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<td>Last Name</td>
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<tr>
<td>Permanent Address ____________________________________________</td>
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<td>Street</td>
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Date of Entry at Drury ________/________   Date of Birth ______/______/________   School ID#______________________________

**PART II - To be completed and signed by your healthcare provider.**

**REQUIRED VACCINATIONS**

**A. MMR (MEASLES, MUMPS, RUBELLA)**

Two doses required at least 28 days apart for students born after 1956 and all healthcare professional students.

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. POLIO**

IPV/OPV sequential: IPV #1 ________/________/________    IPV #2 ________/________/________
   M                D                Y                           M               D                Y

OPV #3 ________/________/________    OPV #4 ________/________/________
   M                 D                Y                               M                D                Y

**C. DIPHTHERIA, PERTUSSIS, TETANUS (DPT)**

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

Dose #4________/________/________              Dose #5 ________/________/________
   M                 D               Y       M                 D               Y

Date of most recent booster dose (must be within the last 10 years): ________/________/________
   M                D                Y

Type of booster: Td _____ Tdap _____
RECOMMENDED VACCINATIONS

D. HEPATITIS B
1. Immunization (hepatitis B)
   Dose #1 __________/________/________    Dose #2 __________/________/________    Dose #3 __________/________/________
   M               D                Y                 M                D                Y                    M                D                Y

2. Hepatitis B surface antibody __________/________/________   Result: Reactive ________ Non-reactive ________
   M                D                Y

E. VARICELLA (Chicken Pox)
1. History of Disease Yes _____ No _____ or Birth in U.S. before 1980 Yes _____ No _____

2. Varicella antibody __________/________/________   Result: Reactive ________ Non-reactive ________
   M               D                Y

3. Immunization
   Dose #1 ................................................................................................... #1 __________/________/________
   M               D                Y                                      M                 D                  Y
   Dose #2 given at least 12 weeks after first dose ages 1-12 years .....#2 __________/________/________
   and at least 4 weeks after first dose if age 13 years or older.                       M               D                Y

F. MENINGOCOCCAL (Meningitis)
One or 2 doses for all college students - revaccinate every 5 years if increased risk continues.
1. Dose #1 __________/________/________ Dose #2 __________/________/________

MENINGOCOCCAL VACCINE WAIVER
For individuals 18 years of age and older: I have read the information in the Meningococcal Disease Fact Sheet at www.cdc.gov/meningococcal, written by the Center for Disease Control and Prevention, explaining the risks of meningococcal disease and the potential benefits of vaccination. I also understand the vaccine is available through my private health care provider or Health department. I have not yet received the vaccine, although, at my discretion, I may choose to do so at some time in the future.

Student Signature:____________________________________________________  Date:_______________________
_______________________________________________________________________________________________________________________________________________________

Healthcare Provider’s Signature:___________________________________________________________________________
Healthcare Provider’s Printed Name: _________________________________________________________________________
Address: ____________________________________________________________________________________________________
Phone Number: _____________________________________________________________________________________________

Upon completion of this form please submit to:

Drury University
Attn: Dean of Students Office
900 N. Benton Avenue
Springfield, MO 65802