HISTORY

CURRENT MEDICATIONS

Y	N			Y	N
		!4"7-74',&%	%VVVVVVVVVVVVVVVVV%	O	O
		34772%"47*,%'#%4$1,;%40#1,%	%VVVVVVVVVVVVVVVVV%	O	O
		:(#"$6% %	%VVVVVVVVVVVVVVVVV%	O	O
		?56,,'7#%	%VVVVVVVVVVVVVVVVV%	O	O
				O	O
				O	O

NAME: _____ **Date of Birth:** _____/_____/_____ **& OIDD** _____

T-SPOT (IGRA) (Date given) _____/_____/_____ (Result) _____ (attach copy of result)
Month Day Year

***Chest x-ray** (Date given) _____/_____/_____ (Date read) _____/_____/_____ (Result) _____
Month Day Year Month Day Year

(*[illegible])

C. RECOMMENDED IMMUNIZATIONS:

1. HUMAN PAPILLOMAVIRUS (HPV) Series of three vaccines (either bivalent or quadrivalent) recommended for females age 11-26 years; series of three vaccines (quadrivalent) recommended for males 9-26 years.

HPV Type GARDASIL (HPV 4 quadrivalent) CERVARIX (HPV2 bivalent)
(Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year

2. HEPATITIS B Series of three vaccines, or positive titer (attach copy of titer results) **May be combined with Hepatitis A

HEP B (Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year

HEP A-B (Date given) _____/_____/_____ (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year Month Day Year
Positive laboratory/serologic evidence of immunity or prior infection may be substituted (attach copy)

3. HEPATITIS A Series of two vaccines **May be combined with Hepatitis B

HEP A (Date given) _____/_____/_____ (Date given) _____/_____/_____
Month Day Year Month Day Year

4. VARICELLA Series of two doses, given at least one month apart; Documented clinical history of chicken pox; or a positive Varicella titer (attach copy)

VARICELLA (Date given) _____/_____/_____ (Date given) _____/_____/_____ OR Illness_____/_____/_____
Month Day Year Month Day Year Month Day Year

5. Tdap (tetanus, diphtheria and acellular pertussis) Single dose recommended for all students age 64 years or younger

TDAP (Date given) _____/_____/_____
Month Day Year

D. EXEMPTIONS:

This student is exempt from the following immunizations on grounds of permanent medical contraindication OR religious
H [H P S W L R Q D W W D F K R I ¿ F L D O G R F X P H Q W D W L

This student is exempt from the following immunizations until _____/_____/_____, **due to** _____.
D W W D F K R I ¿ F L D O G R M Month X P Day Q W Year D W L R Q

E. HEALTHCARE PROVIDER SIGNATURE OR STAMP REQUIRED*

Name: _____ Date: _____/_____/_____
(Please Print) Month Day Year

Address: _____(____)_____
Street/PO Box City State Zip Code Phone

*SIGNATURE _____ Date: _____/_____/_____
(Required of healthcare provider) Month Day Year

After completion of this form, return to:
6 W X G H Q W + H D O W K & H Q W H U 0 D J Q R O D 6