UNIVERSITY OF PITTSBURGH STUDENT HEALTH SERVICE
DATA AND IMMUNIZATION RECORD

THIS FORM DOES NOT REQUIRE A PHYSICIAN'S SIGNATURE. THE INFORMATION CAN BE ENTERED BY THE STUDENT OR PARENT/GUARDIAN. ALL INFORMATION MUST BE IN ENGLISH. **COPIES** OF ORIGINAL RECORDS ARE ALSO ACCEPTABLE. **DO NOT SEND ORIGINAL RECORDS.**

PART I: STUDENT INFORMATION

(ALL FIELDS MUS T BE COMPLETED)

STUDENT IDENTIFICATION NUMBER ______________________________ DATE OF BIRTH _________________________
(MONTH/DAY/YEAR)

NAME ____________________________ / ____________________________ / _______________________
(LAST NAME) (FIRST NAME) (MIDDLE NAME)

ADDRESS ____________________________ / ____
(STREET) (CITY/STATE/ZIP)

TELEPHONE ___________________________________ E-MAIL ____________________________________

PART II: REQUIRED IMMUNIZATIONS

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF POSITIVE LAB/SEROLOGIC EVIDENCE[1]
MMR[2] MEASLES, MUMPS, RUBELLA	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
MMRV[2] MEALES, MUMPS, RUBELLA, +VARICELLA	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
MEASLES	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
MUMPS	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
RUBELLA	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
VARICELLA[3]	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____
MENINGOCCOCAL QUADRIVALENT[4] Required if living in University housing.	____ / ____ / ____	____ / ____ / ____	____ / ____ / ____

1 IF USING A TITER RESULT/SEROLOGIC EVIDENCE FOR PROOF OF IMMUNIZATION, A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW. PLEASE INDICATE THE DATE OF THE TITER IN THE APPROPRIATE FIELD.
2 TWO DOSES OF EITHER MMR/MMRV ARE REQUIRED
3 HISTORY OF CHICKEN POX, A POSITIVE VARICELLA ANTIBODY, OR TWO DOSES OF VACCINE GIVEN AT LEAST ONE MONTH APART ARE REQUIRED. IN CASE OF HISTORY OF DISEASE, PLACE DATE OF DISEASE IN FIRST DATE FIELD.
4 REQUIRED IF LIVING IN UNIVERSITY HOUSING. TWO DOSES ARE REQUIRED, WITH ONE DOES ADMINISTRATED AT 16 YEARS OLD OR OLDER.

IMMUNIZATION EXEMPTIONS

A written exemption statement must be submitted to the Student Health Service for review. Please be aware, if an outbreak of measles, mumps, rubella, or chicken pox occurs, the Allegheny County Health Department may exclude students from classes who do not provide proof of immunity to these circulating diseases. If applicable, students must complete "Exemption to Immunization Requirement" and submit with this form.

PART III: RECOMMENDED IMMUNIZATIONS

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY
TETANUS-DIPTHERIA[5]	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____
POLIO[6]	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____
HPV9-Valent Gardasil[7]	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____	
HEPATITIS B[8]	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____	DATE OF POSITIVE LAB/ SEROLOGIC EVIDENCE ____/ ____/ ____
HEPATITIS A[9]	____/ ____/ ____	____/ ____/ ____		
HEP A AND HEP B COMBINED VACCINE[10]	____/ ____/ ____	____/ ____/ ____	____/ ____/ ____	

5 PRIMARY SERIES WITH DTaP OR DTP AND BOOSTER WITH Td IN THE LAST 10 YEARS MEETS REQUIREMENT.
6 PRIMARY SERIES IN CHILDHOOD MEETS REQUIREMENT; THREE PRIMARY SERIES SCHEDULES ARE ACCEPTABLE. (OPV ALONE ORAL SABIN THREE DOSES] IPV/OPV SEQUENTIAL OR IPV ALONE [INJECTED SALK FOUR DOSES].
7 THREE DOSES OF VACCINE MEET REQUIREMENT.
8 THREE DOSES OF VACCINE OR TWO DOSES OF ADULT VACCINE IN ADOLESCENTS 11-15 YEARS OF AGE. IF USING A TITER RESULT/SEROLOGIC EVIDENCE FOR PROOF OF IMMUNIZATION, A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW. PLEASE INDICATE THE DATE OF THE TITER IN THE APPROPRIATE FIELD.
9 TWO DOSES OF VACCINE MEET REQUIREMENT.
10 THREE DOSES OF VACCINE MEET REQUIREMENT.

PART IV: FOR HIGH-RISK GROUPS ONLY

(As recommended by physician)

PNEUMOCOCCAL POLYSACCHARIDE VACCINE	____ / ____ / ____	
TUBERCULOSIS SKIN TEST	DATE ADMINISTERED ____ / ____ / ____	DATE READ ____ / ____ / ____
	RESULT: ☐ POSITIVE ☐ NEGATIVE	INDURATION (IF NONE MARK '0'): _______mm
CHEST X-RAY[11]	RESULT: ☐ NORMAL	RESULT: ☐ ABNORMAL
TUBERCULOSIS QUANTIFERON GOLD BLOOD TEST[12]	RESULT: ☐ NEGATIVE	RESULT: ☐ POSITIVE

11 REQUIRED IF TUBURCULIN SKIN TEST IS POSITIVE. A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW.
12 IF USING QUANTIFERON GOLD BLOOD TEST TO PROVE IMMUNITY, A COPY OF THE RESULTS MUST ACCOMPANY THIS FORM FOR REVIEW.

I ACKNOWLEDGE THAT THE ABOVE IMMUNIZATION INFORMATION IS ACCURATE AND COMPLETE.

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STUDENT SIGNATURE **DATE**

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412-383-1820 – Fax
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