

IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Due June 8 for Fall entry, December 1 for Spring entry

Name: _____ URID: _____ Date of Birth: _____

Virginia State Law and the University of Richmond Require the Following Immunizations

1) MMR (Measles, Mumps, Rubella) _____ → Dose #1 (MM/DD/YYYY) ___/___/___
Two doses live vaccine required at or after 12 months of age, at least one month apart → Dose #2 (MM/DD/YYYY) ___/___/___

Use ONLY If vaccinated separately:

Measles: Dose #1 ___/___/___ Dose #2 ___/___/___ **Mumps:** Dose #1 ___/___/___ Dose #2 ___/___/___
Rubella: Dose #1 ___/___/___

Use ONLY If titers were drawn:

Measles Titer Date: (MM/DD/YYYY) ___/___/___ Result: _____ **Mumps Titer Date:** (MM/DD/YYYY) ___/___/___ Result: _____
Rubella Titer Date: (MM/DD/YYYY) ___/___/___ Result: _____

If not vaccinated, date of documented disease:

Measles: (MM/DD/YYYY) ___/___/___ **Mumps:** (MM/DD/YYYY) ___/___/___ **Rubella:** (MM/DD/YYYY) ___/___/___

2) Tdap (TETANUS/DIPHTHERIA/PERTUSSIS): (MM/DD/YYYY) ___/___/___ (If vaccine date is older than 10 years, revaccinate.)

OR

Td (TETANUS/DIPHTHERIA): (MM/YY/YYYY) ___/___/___ (If vaccine date is older than 10 years, revaccinate)

3) MENINGOCOCCAL MCV VACCINE: (MM/DD/YYYY) ___/___/___ (Vaccine date must be after student turned 16. If not, revaccinate

OR

MENINGOCOCCAL MPSV VACCINE: (mm/dd/yyyy) ___/___/___

or sign waiver on web portal.)

4) HEPATITIS B VACCINE: (3 doses required or sign waiver on web portal)

Dose #1: (MM/DD/YYYY) ___/___/___

Dose #2: (MM/DD/YYYY) ___/___/___

Dose #3: (MM/DD/YYYY) ___/___/___

5) POLIO OPV VACCINE: (Last dose must be given after 4th birthday. If last dose given prior to 4th birthday, on web portal) Last Dose Date: (MM/DD/YYYY) ___/___/___

OR

POLIO IPV VACCINE: (Last dose must be given after 4th birthday. If last dose given prior to 4th birthday, sign waiver on web portal) Last Dose Date: (MM/DD/YYYY) ___/___/___

Verified by :

Health Care Provider's Signature



Name Printed

Address

Phone

Date

RECOMMENDED IMMUNIZATIONS (NOT Required for Admission)

Name: _____ **URID:** _____ **Date of Birth:** _____

A. VARICELLA VACCINE: Dose #1(MM/DD/YYYY):___/___/___ Dose #2(MM/DD/YYYY):___/___/___
OR Date of documented disease: Month___/Year___

B. HEPATITIS A VACCINE (2 doses vaccine given at 0, 6-12 months) Dose #1(MM/DD/YYYY):___/___/___ Dose #2(MM/DD/YYYY):___/___/___

C. HPV 4 (HUMAN PAPILLOMAVIRUS VACCINE): (3 doses at 0, 2, and 6 month intervals)
Dose #1:(MM/DD/YYYY)___/___/___ Dose #2:(MM/DD/YYYY)___/___/___ Dose #3:(MM/DD/YYYY)___/___/___

D. HPV 9 (HUMAN PAPILLOMAVIRUS VACCINE): (3 doses at 0, 2, and 6 month intervals)
Dose #1:(MM/DD/YYYY)___/___/___ Dose #2:(MM/DD/YYYY)___/___/___ Dose #3:(MM/DD/YYYY)___/___/___

E. Trumenba or Bexsero (MENINGOCOCCAL B NOS VACCINE)
Dose #1:(MM/DD/YYYY)___/___/___ Dose #2:(MM/DD/YYYY)___/___/___ Dose #3:(MM/DD/YYYY)___/___/___

F. PNEUMOCOCCAL VACCINE PCV MM/DD/YYYY ___/___/___

G. PNEUMOCOCCAL VACCINE PPSV MM/DD/YYYY ___/___/___

Verified by : _____ **Health Care Provider's Signature**

Name Printed _____

Address _____

Phone _____

Date _____