MARYMOUNT UNIVERSITY
STUDENT HEALTH SERVICES IMMUNIZATION FORM

Name: _____ Student ID#: _____

Date of Birth (M/D/YY): _____ Cell phone #: _____

REQUIRED

MMR (Measles, Mumps, Rubella) - *2 doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps, and/or Rubella. Choose only one option.*
IF YOU WERE BORN PRIOR TO JANUARY 1, 1957 YOU ARE EXEMPT

Option 1	Vaccine	Date	
MMR *2 doses of MMR vaccine*	MMR Dose #1 MMR Dose #2		

Option 2	Vaccine or Test	Date	Serology Results
Measles *2 doses of vaccine or positive serology*	Measles Vaccine #1 Measles Vaccine #2 Serologic Immunity (IgG antibody titer)		Qualitative Test Results: ☐ Positive ☐ Negative Quantitative Titer Results: _____IU/m
Mumps *2 doses of vaccine or positive serology*	Mumps Vaccine #1 Mumps Vaccine #2 Serologic Immunity (IgG antibody titer)		Qualitative Test Results: ☐ Positive ☐ Negative Quantitative Titer Results: _____IU/m
Rubella 1 dose of vaccine or positive serology	Rubella Vaccine Serologic Immunity (IgG antibody titer)		Qualitative Test Results: ☐ Positive ☐ Negative Quantitative Titer Results: _____IU/m

Tetanus-diphtheria-pertussis - *1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of booster*

	Tdap Vaccine (Boostrix, Adacel, etc.) Td Vaccine or Tdap Vaccine booster (if more than 10 years since last)		

MU SHS Immunization Record (cont.)

Name: _____ ID #: _____

Meningococcal *-1 dose between the age of 16 years to 23 years*

	Meningococcal Vaccine	_____	

Meningitis B - *2 doses or have started the 2 dose series between the age of 16-23 years*

☐ Bexsero ☐ Trumenba	Men B #1 _____ Men B #2	_____	

Hepatitis B - *2 or 3 dose series **OR** signed WAIVER*

☐ Engerix-B/Recombivax ☐ Heplisav-B (2 doses) ☐ WAIVER (p.6)	Hepatitis #1 _____ Hepatitis #2 _____ Hepatitis #3	_____ _____	Qualitative Test Results: Immune ☐ Yes ☐ No Quantitative Titer Results: _____mIU/mL

Polio - *for students under 18 years*

Polio (IPV)	Date series completed:		

NOT REQUIRED, BUT RECOMMENDED:

Hepatitis A	#1	#2	
COVID	#1	#2	#3
Varicella	#1	#2	

Providers official address: Stamp:

_____

_____

Signature of HCP: Date:

_____ _____

***** *Student Health Clinic carries all required vaccinations if unable to get prior to coming to campus. Your insurance will be verified prior to administration. Please call 703-284-1610 if you have questions or would like to make an appointment.*

*** Only students attending classes in-person need to submit immunizations. If you are online, please let SHS know.*