Samford University
College of Health Sciences

Program of Study _____
SUID # _____

# IMMUNIZATION/TITER HISTORY

_____ _____

**LAST NAME** **FIRST NAME** **MIDDLE** **BIRTH DATE**

***All CHS students must complete an immunization/titer history before enrolling in classes. Please refer to your program/school Student Handbook for specific information on immunization requirements.***

## MMR (Measles, Mumps, and Rubella)

If born before 1957, no MMR immunizations are required

*Combined Vaccines (Two doses at least one month apart)*

| | | |
|---|---|---|
| MMR | #1 ____/____/_____ month/day/year | #2 ____/____/_____ month/day/year |

**OR**

*Laboratory Evidence of Immunity*

| | | |
|---|---|---|
| Measles | ____/____/_____ month/day/year | ____ Immune ____ Non-Immune |
| Mumps | ____/____/_____ month/day/year | ____ Immune ____ Non-Immune |
| Rubella | ____/____/_____ month/day/year | ____ Immune ____ Non-Immune |

**If not immune, complete vaccination series*

## Tdap (tetanus-diphtheria-acellular pertussis)

*One dose administered within the last 10 years. Other Tetanus vaccine types are NOT acceptable.*

____/____/_____
month/day/year

## Varicella (Chickenpox)

*History of Disease*

____/____/_____
month/day/year

(A minimum of the Month/Year REQUIRED)

**OR**

*Vaccines*

| | |
|---|---|
| #1 ____/____/_____ month/day/year | #2 ____/____/_____ month/day/year |

**OR**

*Laboratory Evidence of Immunity*

____/____/_____
month/day/year

____ Immune
____ Non-Immune

**If not immune, complete vaccination series*

## Hepatitis B*

*Vaccines*

| | | |
|---|---|---|
| #1 ____/____/_____ month/day/year | One month after dose 1 #2 ____/____/_____ month/day/year | Five months after dose 2 #3 ____/____/_____ month/day/year |

**OR**

*Laboratory Evidence of Immunity*

| | |
|---|---|
| ____/____/_____ month/day/year<br>____ Immune<br>____ Non-Immune | *This must be a <u>*Hepatitis B Surface Antibody Titer*</u> that indicates you are IMMUNE to Hepatitis B. |

**If not immune, complete vaccination series*

*Comments:* _____

***Form must be completed by one of the following licensed healthcare providers: MD, DO, NP/CRNP, PA, RN, LPN, or Pharmacist. The form must be dated <u>NO EARLIER THAN</u> the last listed vaccination or lab test for the form to be valid. Nothing should be added to form after the healthcare provider signs and dates <u>UNLESS</u> the individual addition is signed, credentialed, and dated.***

Licensed Healthcare Provider's Printed Name and Credentials: _____

Facility Name: _____

Facility Address: _____

City: _____ State: _____ Zip: _____

SIGNATURE OF PROVIDER: _____ DATE: _____

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**There are other vaccinations to address based on situation.**

- If a student lives in campus housing, a Meningococcal (quadrivalent - A,C,Y, W-135) vaccine must have one dose administered since 16th birthday. **Living in Campus Housing?** Yes [ ] No [ ]

  Date given: ____/____/____

- All CHS graduate students must receive an annual influenza vaccination; student should obtain this vaccination annually each fall. Provide most recent dose, if received.

  Date given: ____/____/____

- COVID-19 vaccination strongly recommended. Although not required by the University, clinical sites may require it, and lack of vaccination may delay or prevent clinical placements.

  Name of vaccination: _____

  Date given: Dose #1____/____/____
  Dose #2 ____/____/____ (if applicable)

*Comments:* _____

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