Augustana College

Immunization Record

To be completed and signed by health care provider.* ALL DATES MUST INCLUDE MONTH, DAY AND YEAR.

SOCIAL SECURITY NUMBER_____-_____-_____

_____
LAST NAME (PLEASE PRINT)   FIRST

(   ) Male (   ) Female

_____
STUDENT I.D. NUMBER   DATE OF BIRTH (MONTH/DAY/YEAR)   SEX ASSIGNED AT BIRTH

_____
ADDRESS   CITY   STATE   ZIP

Required Immunizations	1 MO DAY YR	2 MO DAY YR	3 MO DAY YR	4 MO DAY YR	5 MO DAY YR
Diphtheria, Pertussis and Tetanus (DPT)					
Diphtheria and Tetanus (Td or TD)					
Combined Measles, Mumps/Rubella (MMR)					
Combined Measles and Rubella (MR)					
Rubeola (Red Measles) Live Virus Vaccine					
Rubella (3-day or German Measles)					
Mumps					

1. Clinic diagnosis of rubeola and mumps acceptable if verified by physician with specific date.
   Rubeola: _____/_____
   Mumps: _____/_____
2. **Lab confirmation** of rubella, rubeola or mumps is acceptable. ATTACH COPY OF LAB RESULTS.

Meningitis #1_____ #2_____

1. First dose given between ages 11-16.
2. Booster dose given on or after age 16.

TUBERCULOSIS (for non-U.S. residents only)

1. Tuberculin Skin Test: Date Given _____   Date Read _____
                                          (MONTH/DAY/YEAR)   (MONTH/DAY/YEAR)

   Result: _____ (Record actual mm of induration, transverse diameter, if no induration, write "0")
   Interpretation (based on mm of induration as well as risk factors): Positive _____Negative _____

2. Chest x-ray (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

_____   INH _____
(MONTH/DAY/YEAR)   (MONTH/DAY/YEAR)

Optional Immunizations (please record dates given)   Hepatitis B   #1_____   #2_____   #3_____

_____
PHYSICIAN OR OTHER HEALTH CARE PROVIDER SIGNATURE AND TITLE

_____
NAME (PRINT)

_____
ADDRESS

_____
TELEPHONE

*Physician licensed to practice medicine in all of its branches (M.D. or D.O.) or local health authority or Registered Nurse employed by a school, college, or university or a Department Recognized Vaccine Provider.

FOR OFFICE USE ONLY

Reviewed by_____Date_____ [   ] Complete [   ] Incomplete

		Measles (Rubeola)	Rubella (German Measles)	Mumps	Tetanus Diphtheria	Meningitis
	Immune	[ ]	[ ]	[ ]	[ ]	[ ]
EXEMPT:	Medical	[ ]	[ ]	[ ]	[ ]	[ ]
	Religious	[ ]	[ ]	[ ]	[ ]	[ ]