# Immunization Form for On-Campus Students

## Required Immunizations

<table>
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<tr>
<th>Name</th>
<th>First Name</th>
<th>Middle Name</th>
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<tr>
<th>Last Name</th>
<th>Address</th>
<th>Street</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<tr>
<th>Date of Entry</th>
<th>Date of Birth</th>
<th>School ID #</th>
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### M.M.R. (MEASLES, MUMPS, RUBELLA)
(Two doses required at least 28 days apart for students born after 1956)

1. Dose 1 given at age 12 months or later. .................................................. 
   #1 ______/____/____  
   M D Y

2. Dose 2 given at least 28 days after first dose. ...........................................  
   #2 ______/____/____  
   M D Y

### POLIO
(Primary series, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses): #1 ______/____/____ #2 ______/____/____ #3 ______/____/____

2. IPV/OPV sequential: IPV #1 ______/____/____ IPV #2 ______/____/____ OPV #3 ______/____/____
   OPV #4 ______/____/____

3. IPV alone (injected Salk four doses): #1 ______/____/____ #2 ______/____/____ #3 ______/____/____
   #4 ______/____/____

### TETANUS-DIPHTHERIA-PERTUSSIS
(Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years. Health sciences students with patient contact)

1. Primary series of four doses with DTaP, DTP, DT, or Td:  
   #1 ______/____/____ #2 ______/____/____ #3 ______/____/____ #4 ______/____/____

2. Booster: Tdap (preferred) to replace a single dose of Td for booster immunization at least 2-5 years since last dose of Td, depending on age of patient. (Administer with MCV4 simultaneously if possible). ........................................... ______/____/____

3. Booster: Td within the last ten years. ................................................................. ______/____/____

### HEPATITIS A
1. Immunization (hepatitis A)
   a. Dose #1 ______/____/____  b. Dose #2 ______/____/____

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ______/____/____  b. Dose #2 ______/____/____  c. Dose #3 ______/____/____

### H. HEPATITIS B
1. Immunization (hepatitis B)
   a. Dose #1 ______/____/____  b. Dose #2 ______/____/____  c. Dose #3 ______/____/____

   Adult formulation  Child formulation  Adult formulation  Child formulation  Adult formulation  Child formulation

2. Immunization (Combined hepatitis A and B vaccine)
   a. Dose #1 ______/____/____  b. Dose #2 ______/____/____  c. Dose #3 ______/____/____
3. Hepatitis B surface antibody Date __/__/____ Result: Reactive______ Non-reactive______
Date __/__/____

MENINGOCOCCAL TETRAVALENT
Tetravalent conjugate (preferred; data for revaccination pending; administer simultaneously with Tdap if possible):
Date ____/____/____

TB Skin Test (INTERNATIONAL STUDENTS ONLY)
PPD (Mantoux) within 6 months prior to first enrollment. Date placed: _____/____/_____ Date read: _____/____/_____ Result: ___ mm of induration ___ NEG ___
POS Chest x-ray (required if TB skin test is positive) Date of x-ray: ______________ Result: _____ Normal _____Abnormal

RECOMMENDED IMMUNIZATIONS

INFLUENZA
(Trivalent inactivated influenza vaccine or TIV. Live attenuated influenza vaccine or LAIV; licensed for healthy, nonpregnant persons age5–49 years old. Annual immunization recommended to avoid influenza complications in high-risk patients, to avoid disruption to academic activities, and to limit transmission to high-risk individuals.)

PNEUMOCOCCAL POLYSACCHARIDE VACCINE
(One dose for members of high-risk groups.)

VARICELLA
(Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement.)

HEALTH CARE PROVIDER
Name _________________________________________________________________________________________________
Address _________________________________________________________________________________________________
Phone _________________________________________________________________________________________________
Signature _______________________________________________________________________________________________

NOTE: Immunizations may be obtained at the physician’s office or clinic of your choice, county health department immunization clinic if your county has one and if you are eligible. These forms will be verified by a public health nurse.

PLEASE MAIL THIS FORM BACK TO:

Student Life Office
Western Nebraska Community College
1601 East 27th Street
Scottsbluff, NE 69361
ATTN: Immunizations

Or Fax it to: 308-635-6732