Western Nebraska Community College

Immunization Form for On-Campus Students

Required Immunizations

Name _____
Last Name First Name Middle Name

Address _____
Street City State Zip

Date of Entry ____/____ Date of Birth _____/_____/_____ School ID # _____
M D Y

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
s

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