



IMMUNIZATION RECORD

FOR HEALTH SERVICES
USE ONLY

Date Record Entered:

____/____/____

Reviewed by: _____
(Initial)

First Full-Time Semester: _____ Year: _____
(Fall or Spring)

PART 1

Student ID# _____

Student:

(Last Name) (First Name) (MI)

Address:

(Street) (City) (State) (Zip Code)

Phone _____ Date of Birth ____/____/____

Part 2

Must be completed by primary care provider and signed OR attach a copy of official immunization form.

MEASLES, MUMPS, RUBELLA SERIES:

Combination vaccine of measles (M), mumps (M), and Rubella (R) – 2 vaccines are required

MMR#1 ____/____/____ MMR#2 ____/____/____

HEPATITIS B SERIES:

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____

MENINGITIS SERIES:

If you turn 23 years old in your first semester at CCM, you can disregard this section

Option 1: MENACWY Dose 1: ____/____/____ Dose 2: ____/____/____

Option 2: Men B Dose 1: ____/____/____ Dose 2: ____/____/____

PHYSICIAN/OR OTHER HEALTH CARE PROVIDER (not necessary if official copy of immunization record is included/attached):

Name: _____ Address: _____

(Please Print)

Signature: _____ Phone: _____