IMMUNIZATIONS REQUIRED

STUDENT'S NAME______________________________ **Date of Birth (mm/dd/yyyy)** ____/___/______

1. Please fill out the form below with the dates the shots/disease occurred based on your immunization paperwork/card.
2. You also need to provide your immunization paperwork/card from a health facility/doctor. It must have an official stamp.
3. Provide an English translation of your immunization card.
4. Please obtain all the required immunizations before departure from your home country. You will not be allowed to attend classes until this requirement has been met.

IMMUNIZATION NEEDED:

A. **Four** doses of polio vaccine (TOPV) (**3 doses** acceptable if one given after child's *2nd* birthday)
B. **Four** doses of Diphtheria, Tetanus, and Pertussis - DPT, Td, Dt, or DTaP for ages 7-17 (**3 doses** acceptable if one was given after child's *second* birthday)
C. **Two** doses MMR (**1 dose** acceptable if given after *first* birthday)
D. **Three** doses of Hepatitis B vaccine (2 doses acceptable if the 2-dose Hepatitis B vaccine formulation was used and both doses were given between ages 11-15; Doctor must document that it was the 2-dose Hepatitis B formulation)
E. **One** dose of Varicella vaccine (**2 doses** required if first dose issued after *thirteenth* birthday. Had disease is also acceptable if verified by doctor)
F. **(NEW LAW) One dose** of Booster shot of Tdap, DTaP or DTP (for Pertussis) is **required** after child's *7th* birthday. **Td does not meet this requirement.**

VACCINE		**DATES (mm/dd/yyyy)**			
A. TOPV/OPV or IPV (Polio)	1st __/__/__	2nd __/__/__	3rd-*Complete if after second* birthday __/__/__	(4th) __/__/__	
B. DTP/DTaP/ DT/Td (Diphtheria, Tetanus, and Pertussis)	1st __/__/__	2nd __/__/__	3rd-*Complete if after second birthday* __/__/__	(4th) __/__/__	
C. MMR (Measles, Mumps, Rubella)	1st- *Complete if after first* birthday __/__/__	(2nd) __/__/__			OR had disease; doctors' signature ________
D. Hepatitis B	1st __/__/__	2nd __/__/__	3rd __/__/__		
E. Varicella (Chickenpox)	1st __/__/__	(2nd) Required if first shot given after 13th birthday __/__/__			OR had disease; doctors' signature ________
F. Pertussis Booster Tdap (whooping cough)	1st After 7th birthday __/__/__				

Signature of Physician: ____________________ *Date* ________ ***Official Seal/Stamp Here***

Revised 04/20/12