

Immunization Record Form

PART I - To be completed by student and filled out in pen.

Name _____ Date of Birth _____/_____/_____

Last First Middle Month Day Year

Permanent Address _____

City _____ State _____ Zip/Postal Code _____ Country _____

Home Phone (_____) _____ Student's Cell Phone (_____) _____

Will you be using this cell phone at CLU? Yes No

CLU Email _____

Date of entry at CLU _____/_____/_____ Status: On campus (residential student) Commuter (living off-campus)

PART II – To be completed and signed by your health care provider or provide copy of official immunization record.
All information must be in English.

A. REQUIRED IMMUNIZATIONS

MMR, Tetanus, and Hepatitis B vaccines are required for residential students, athletes and cheerleaders. They are strongly recommended for all students. Commuter students only need to fulfill the MMR vaccine requirement.

Please list dates as: **Month/Day/Year**

1. MMR - Measles, Mumps and Rubella

(Two doses of MMR or positive antibody for Rubeola, Mumps and Rubella required for all students)

Dose 1 given on or after age 12 months #1 _____/_____/_____

Dose 2 given at least 28 days after first dose and after 1989 #2 _____/_____/_____

(OR can perform lab testing below and provide copy of lab results)

Rubeola antibody (IgG) titer result Immune Non-Immune Date _____/_____/_____

Rubella antibody (IgG) titer result Immune Non-Immune Date _____/_____/_____

Mumps antibody (IgG) titer result Immune Non-Immune Date _____/_____/_____

2. Tetanus, Diphtheria, Pertussis

(Completion of primary series and a booster with Tdap or Td within the last 10 years meets requirement)

Primary series completed Yes No Date of last dose in series: _____/_____/_____

(AND)

Date of most recent booster dose: _____/_____/_____ (must be within the past 10 years)

Type of booster Tdap Td (Tdap recommended)

3. Hepatitis B

(Three doses of vaccine or a positive Hepatitis B surface antibody meets requirement)

If student has not completed series or is not immune, the first dose is required prior to matriculation and subsequent doses can be given at Health Services.

Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ Dose #3 _____/_____/_____

(OR can perform lab testing below and provide copy of lab results)

Positive Hepatitis B surface antibody (IgG) Date _____/_____/_____ Result: Immune Non-Immune

STUDENT REGISTRATION WILL BE HELD IF ABOVE IMMUNIZATION REQUIREMENTS ARE NOT MET.

PLEASE MAIL COMPLETED
FORM TO HEALTH SERVICES IN
THE ENCLOSED ENVELOPE BY:
AUGUST 1 FOR FALL SEMESTER
JANUARY 2 FOR SPRING SEMESTER



HEALTH SERVICES
60 WEST OLSEN ROAD #4300
THOUSAND OAKS, CA
91360-2700
T: (805) 493-3225
F: (805) 493-3955

B. RECOMMENDED (NOT REQUIRED) IMMUNIZATIONS (Recommended for all students, but student registration will not be held if not documented.)

1. Meningococcal – Strongly Recommended

(A, C, 4, W-135/One or 2 doses for all college students—revaccinate every 5 years if increased risk continues.)

Quadrivalent conjugate vaccine (preferred) Dose #1 ____/____/____ Dose #2 ____/____/____

(OR)

Quadrivalent polysaccharide vaccine Date ____/____/____

2. Varicella (Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine is recommended)

History of disease Yes No (OR) Birth in the U.S. before 1980 Yes No

(OR)

Varicella antibody ____/____/____ Reactive Nonreactive

(OR)

Immunization

Dose #1 ____/____/____

Dose #2, given at least one month after first dose, if age 13 or older ____/____/____

3. Hepatitis A

Dose #1 ____/____/____ Dose #2 ____/____/____

Combined Hepatitis A and B Vaccine

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

4. Human Papillomavirus

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

Indicate which preparation: Quadrivalent (HPV4) Bivalent (HPV2)

MUST BE SIGNED BY HEALTH PROFESSIONAL OR PROVIDE COPY OF OFFICIAL IMMUNIZATION RECORD THAT HAS ALL REQUIRED IMMUNIZATIONS LISTED (PLEASE CHECK DATES)

Health Professional Signature _____ Date ____/____/____

Name (Please Print) _____

Street Address _____ Telephone (____) _____

City _____ State _____ Zip Code _____

REFERENCES FOR HEALTH CARE PROVIDERS:

Advisory Committee on Immunization Practices (ACIP) recommendations.

American College Health Association

“Recommendations for Institutional Prematriculation Immunizations,” March 2011. www.acha.org

PLEASE MAIL THIS COMPLETED FORM IN THE ENCLOSED ENVELOPE TO:

California Lutheran University
Health Services
60 West Olsen Road #4300
Thousand Oaks, CA 91360-2700



OFFICE STAMP HERE



HEALTH SERVICES
60 WEST OLSEN ROAD #4300
THOUSAND OAKS, CA
91360-2700
T: (805) 493-3225
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WWW.CALLUTHERAN.EDU/HEALTH