Student Immunization History Form

Lewis University accepts immunization history documentation in the form of official high school, college, military, and/or medical records. As an alternate option, immunization dates can be transcribed onto this form by your health care provider.

NAME OF STUDENT ______________________ DATE OF BIRTH ______________

STUDENT ID ______________ TELEPHONE NUMBER ______________ EMAIL ADDRESS ______________

HOME ADDRESS, CITY, STATE, COUNTRY ______________________

IMMUNIZATION REQUIREMENTS

Deadline- Fall Semester: September 1 Spring Semester: February 1

✓ **Measles – Mumps - Rubella**

Two doses of MMR vaccine administered on or after the first birthday and at least 28 days apart **OR** positive antibody titers indicating immunity to all three diseases (must include lab report with reference ranges).

✓ **Diphtheria –Tetanus - Pertussis**

Any combination of 3 or more doses of Diphtheria, Tetanus, and Pertussis containing vaccine (DTP, DTaP, DT, Td, or Tdap). The last dose of vaccine must have been received within the last 10 years. ***At least one dose must be a Tdap vaccine.**

✓ **Meningococcal Conjugate Vaccine (MCV4)**

All newly admitted students under age 22 are required to have at least one dose on or after 16 years of age. If received before the age of 16, a booster dose is required. Students who will be age 22 or older on the first day of class of the first semester enrolled are exempt from this requirement.

COVID-19 VACCINE INFORMATION

Students are strongly encouraged to remain up to date with their COVID-19 vaccines, which means a person has received all recommended COVID-19 vaccines, including any booster dose(s) when eligible. If not vaccinated for COVID-19, please write "not vaccinated" in the appropriate space below.

To be completed by a licensed healthcare provider. All dates should be listed as MM/DD/YYYY

VACCINE	DOSE 1	DOSE 2
MMR (Combined Measles, Mumps, Rubella)		
Td/DTP/DTaP – Record at least 2 doses		
Tdap – Record at least one dose		
Meningococcal Conjugate Vaccine (MCV4) **One dose must be administered on or after 16 years of age**		
COVID-19 Primary Series		
COVID-19 Booster		

Licensed Health Care Provider (MD, DO, APRN, PA) verifying above immunizations history. (PRINT CLEARLY/STAMP AND SIGN BELOW)

Name ______________________ Date ____________

Signature ______________________

Address ______________________

Telephone Number ______________________