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 healthcare provider. Immunization records must be submitted by September 1st for the Fall semester and February 1st for the Spring semester.

NAME _____ DATE OF BIRTH _____

STUDENT ID _____ TELEPHONE NUMBER _____ EMAIL ADDRESS _____

HOME ADDRESS, CITY, STATE, COUNTRY _____

IMMUNIZATION REQUIREMENTS

✓ **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 10 years**. ***One dose must be a Tdap vaccine.**

✓ **Meningococcal Conjugate Vaccine (MCV4)**
All new admitted students under age 22 are required to have at least one documented 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.

PLEASE ENTER VACCINE DATES IN THE SPACE BELOW USING THE MM/DD/YYYY FORMAT.

VACCINE	DATE	DATE
MMR (Combined Measles, Mumps, Rubella)		
Tdap – Record at least one dose		
Td/DTP/DTaP – Record at least 2 additional doses		
Meningococcal Conjugate Vaccine (MCV4)		
Covid 19 Primary Series - Please indicate which vaccine was received and date(s) of administration.		
Covid 19 Booster - Please indicate which vaccine was received and date(s) of administration.		

Licensed Health Care Provider (MD, DO, APN, PA) verifying above immunization history must print clearly/stamp and sign below.

Signature _____

Name _____

Address _____

Telephone Number _____ Date of Verification _____