UNION UNIVERSITY
HEALTH SERVICES

IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.

If you have proof of your required vaccinations, the following form does not have to be completed. Simply email your records to clinic@uu.edu.

If vaccinations or proof of vaccinations are still needed, please provide the following form to your healthcare provider for completion.

STUDENT NAME		DOB:	
ADDRESS:		PH#	

REQUIRED VACCINES	VACCINE DOSES ADMINISTERED		
MEASLES, MUMPS, RUBELLA (MMR) Students born before 1957 are not required to have a second MMR vaccination	#1 _____ / _____ / _____	#2 _____ / _____ / _____	TITER: _____ / _____ / _____ (see attached results)
VARICELLA (CHICKENPOX) Two doses one month apart for adults with no history of disease History of Disease Date: _____ / _____ / _____	#1 _____ / _____ / _____	#2 _____ / _____ / _____	TITER: _____ / _____ / _____ (See attached results)
MENINGOGOCCAL (Meningitis ACWY) Must have at least one vaccine after the age of 16.	#1 _____ / _____ / _____	#2 _____ / _____ / _____	

Tuberculosis Test Results

TB SKIN PPD PLACED: _____ / _____ / _____ READ: _____ / _____ / _____	mm and range REQUIRED (check box) O 0 mm O 0 to <5 mm O 5 to <10 mm O 10 to < 15 mm O 15 mm or larger	TB BLOOD QUANTIFERON TEST _____ / _____ / _____ RESULTS: O POSITIVE O NEGATIVE	TB CHEST XRAY DATE: _____ / _____ / _____

REQUIRED – Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

LICENSED CARE PROFESSIONAL SIGNATURE	PRINTED LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NPI NUMBER	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

RECOMMENDED VACCINES

Recommended for your general well-being, but not required.

Tetanus-Diphtheria (Tdap) within 10 years	Hepatitis B
Meningitis B	HPV
Polio	COVID-19
Hepatitis A	Influenza (FLU)

---------- FOR OFFICE USE ONLY ----------

☐ VERIFIED ☐ MISSING VACCINE(S) ☐ MISSING TB ☐ HOLD PLACED ON ACCT. ☐ HOLD LIFTED