

THE UNIVERSITY OF WEST FLORIDA

Immunization Form

DEMOGRAPHICS:

Name: _____ DOB: _____

Local Address: _____

Required Immunizations: (ALL are required)

Lab tests can take several weeks to get results.

PLAN ACCORDINGLY to meet March 1st deadline date.

HEALTHCARE PROVIDERS please note: both Hepatitis B Series AND titer are required.

Hepatitis B Vaccination Series Dates: (1) _____ (2) _____ (3) _____

Hepatitis B Titer: (*both series AND titer are required*) Results _____ Date _____

Date of Measles, Mumps, Rubella (2 shot series): (1) _____ (2) _____

OR evidence of MMR immunity per titer: Date _____ Results _____

Meningitis: Date _____

Varicella Vaccination Date _____ OR Immunity per titer: Date _____ Results _____

Tetanus Toxoid Booster Date (within last 10 years) _____

TB Skin Test Date (within past 12 months): _____ Results: Negative _____ Positive _____

If positive: Chest x-ray Date: _____ Treatment (if indicated): _____

Practitioner's Signature: _____ Date: _____

Name (Printed): _____

License number: _____ State Licensed: _____

Licensed as (check one):

Physician []

Physician's Assistant []

ARNP []