



**This completed form must be returned to Student Health within four weeks after the date received.  
No registration is complete until this requirement is met.**

**Items A-E must be completed and signed by a health care provider. (Dates of Immunization must be included.)**

**A. Tetanus-Diphtheria**

Date of last tetanus-diphtheria booster (must be within the last 10 years) ..... 

Month	Day	Year	

**B. M.M.R. (Measles, Mumps, Rubella) (2 immunizations required) – If MMR not given skip to B 1 2 3**

Date of 1st Immunization (on or after 1st birthday) ..... 

Month	Day	Year	

Date of 2nd immunization ..... 

Month	Day	Year	

**1. Measles (Rubeola) – (if given instead of MMR)**

Had disease, confirmed by office record ..... 

Month	Day	Year	

Born before January 1, 1957. (consider immune)

Date of positive immune titre ..... 

Month	Day	Year	

Immunized with live measles vaccine ..... 

Month	Day	Year	

  
(2 immunizations required on or after 1st birthday)

**2. Rubella – (if given instead of MMR)**

Had disease, confirmed by office record ..... 

Month	Day	Year	

Date of positive immune titre ..... 

Month	Day	Year	

Immunized with vaccine at age 1 or older ..... 

Month	Day	Year	

**3. Mumps – (if given instead of MMR)**

Had disease, confirmed by office record ..... 

Month	Day	Year	

Immunized with vaccine at age 1 or older ..... 

Month	Day	Year	

Date of positive immune titre ..... 

Month	Day	Year	

**C. Varicella (chickenpox)**

Had disease (document date) ..... 

Month	Day	Year	

Not sure if had disease (titre required) Date of Immune Titre ..... 

Month	Day	Year	

  
Titre result:  Immune  Not Immune

Immunized with vaccine (2 doses required) ..... 

Month	Day	Year	

Month	Day	Year	

**D. Tuberculosis**

You must provide proof of TWO Tuberculosis skin tests (PPD) at least two weeks apart, done within the last 12 months, in which at least one is done within the last six months. If you have a non-negative result, you must attach a copy of a chest X-ray report. Please also include dates of prophylaxis therapy (if completed).

PPD 1 (within last 12 months)	Placement Date	Read Date	Result (mm of induration)
PPD 2 (within last 6 months)	Placement Date	Read Date	Result (mm of induration)

Law students require only one PPD test done within the past year.

**E. Hepatitis B (not required for Law School)**

Dates received: First dose \_\_\_\_\_ Second dose \_\_\_\_\_ Third dose \_\_\_\_\_

PHYSICIAN'S SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

STUDENT'S LAST NAME (please print): \_\_\_\_\_  
Last First Middle SS#

STUDENT HEALTH REVIEWER: \_\_\_\_\_ DATE: \_\_\_\_\_

“Please describe any disability you have as well as any accommodation you may require from Student and Employee Health. Students should convey directly to their school administration the need for an accommodation within the school or related to their program of study.” \_\_\_\_\_

STATEMENT BY STUDENT: I have personally supplied all the above information and attest that it is true and complete to the best of my knowledge.

Signature of Student \_\_\_\_\_ Date: \_\_\_\_\_