EASTERN MENNONITE UNIVERSITY - IMMUNIZATION RECORD

**Please have a health care provider complete this form and sign it at the bottom.

Name: _____ _____
Last Name First Name

EMU ID number: _____ **Age:** _____ **Date of Birth:** _____/_____/_____ **Sex:** ___ **HT:** _____ **WT:** _____
Month – Day – Year

Standing BP: _____ **Sitting BP:** _____ **Pulse:** _____

Glasses - YES NO **Contacts -** YES NO **Eye protection -** YES NO **Vision:** R_____ L_____ **Pupils:** R_____ L_____

Mark each item WNL (Within Normal Limits) or A (Abnormal)		***If any Abnormal, explain in comments.**			
HEENT		**COMMENTS**			**COMMENTS**
Fundoscopic			Dental		
Ears			Nodes		
Mouth			Lungs/chest		
Throat			Thyroid		
Cardiac					
Including precordial auscultation (supine & standing) and femoral artery pulses.					
Abdomen			Neuro		
Genitalia			Depression/Anxiety		
Hernia			Other psych.disorders		
Skin					
Musculoskeletal					
Neck			Hip		
Thoracic/Lumbar			Quad/Hamstring		
Shoulder			Knee		
Elbow			Ankle/Feet		
Wrist/Hands			Gait		

****Required****

Enter your immunizations both online at www.emu.edu/health-online AND provide verification of all dates.

TB screening at a U.S. facility is required.

TB Screening date: _____/_____/_____ RESULT: Positive / Negative **IF POSITIVE, complete a, b, or c below.**

a. PPD (Mantoux) Date Given_____/_____/_____ Date Read_____/_____/_____ Result _____ mm induration (horizontal diameter)

b. IGRA blood test results (T-Spot, Quantiferon Gold) Positive / Negative Date _____/_____/_____

c. Chest x-ray - if positive IGRA blood test or ppd **(attach x-ray report)**

☐ If INH Prophylaxis: Dates: From ____/____/____ To ____/____/____

VACCINE	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE MM/DD/YY	DATE OF TITER/RESULT
DPT series					
Hepatitis B (or sign waiver)					
MMR – measles, mumps, rubella (if born after 1956)					
Meningococcal (or sign waiver)					
Polio-last booster					
TDAP (within 10 yrs.)					
Varicella - chicken pox- (if born after 1979)	Vaccine #1:	Vaccine #2:			**Date of disease:**

The following immunizations are highly recommended but are NOT required.

1. Hepatitis A Dose 1_____/_____/_____ Dose 2_____/_____/_____ Titer: ____/____/____ Result: _____

2. HPV Vaccine Dose 1_____/_____/_____ Dose 2_____/_____/_____ Dose 3_____/_____/_____

Meningitis Waiver - I have read the meningococcal immunization information from the CDC vaccine information sheet at: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-mening.pdf . I have chosen not to be vaccinated.

_____ _____ _____
Signature of Student Printed Name Date

Hepatitis B Waiver - I have read the hepatitis B immunization information from the CDC vaccine information sheet at: http://www.cdc.gov/vaccines/pubs/vis/downloads/vis-hep-b.pdf . I have chosen not to be vaccinated.

_____ _____ _____
Signature of Student Printed Name Date

Health Care Provider: _____ _____ **Date** _____
Signature/Title **Phone Number**

Health Care Provider: _____ _____ _____
PRINT NAME **Address** **Fax Number**