IMMUNIZATIONS **West Liberty University**

Return completed form to:

*WLU Health Service 208 University Drive College Union Box 127*

*West Liberty, WV 26074-0295 or Fax: 304-336-8315*

Confidential Mandatory Health Form



To be completed and signed by your health care provider

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Last, First, MI) Student ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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| Tuberculosis (TB) | Must be completed within the six months prior to entering the program. Applicants with a history of positive tests must provide documentation of appropriate screening and treatment. A history of receiving the BCG vaccine is not a contraindication to skin testing. ***Two-step testing is required*.**    Dates given: 1st) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd) \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M/Y) Results: \_\_\_\_\_\_\_\_\_\_\_mm  Dates read: 1st)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 2nd)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(M/Y) Results: \_\_\_\_\_\_\_\_\_\_\_\_mm    Pos: [ ] Neg [ ]  ***\* Results must be attached***  Chest x-ray results (required if PPD test is positive): Date: (M/Y) Results: |
| Diphtheria/Pertussis/  Tetanus | Primary series of 4 doses with DTaP or DTP  Date given: #1 (M/Y) #2 (M/Y) #3 (M/Y) #4 (M/Y) Tdap Booster: (M/Y) (must be within last 10 years) |
| Measles-Mumps- Rubella (MMR) | Series of 2 doses. Dose 1 at 12-15 months or later, dose 2 at 4-6 yrs. or later and at least one month apart from the 1st.  Date given: #1 (M/Y) Date given: #2 (M/Y)  Measles Antibody titer: Date\_\_\_\_\_\_\_\_\_\_\_\_\_(MY) Results:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***\* Lab results must be attached*** |
| Rubella antibody screening | Antibody titer: Date \_\_\_\_\_\_\_\_\_\_\_\_ (M/Y) Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***\* Lab results must be attached*** |
| Mumps antibody screening | Antibody titer: Date \_\_\_\_\_\_\_\_\_\_\_\_ (M/Y) Results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  ***\* Lab results must be attached*** |
| Influenza | Immunization is required each year. Date given: (M/Y) |
| Hepatitis B | Immunization is required for all students. This series of three immunizations and post- vaccination antibody titer for proof of immunity is required.  Date given: #1 (M/Y) #2 (M/Y) #3 (M/Y) Hepatitis B surface antibody:  Date: (M/Y) Results: ­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_ ***\* Lab results must be attached*** |
| Chicken Pox (Varicella) | History of disease is acceptable (titer still required). If no history, two doses of vaccine at least one month  apart and titer are necessary.  Date given: #1 (M/Y) #2 (M/Y)  Titer date: (M/Y) Results: \_\_\_\_\_\_\_\_\_\_\_\_\_ ***\* Lab results must be attached*** |
| Bacterial Meningitis (highly recommended) | Date given: (M/Y) |

Health Care Provider’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_