THE COLLEGE *of* IDAHO
Idaho's Liberal Arts College

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Caldwell, ID 83605
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Immunization Record

Name ____

Address____Street City State Zip

Date of Birth ____/____/________

TO BE COMPLETED AND SIGNED. All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later . #1 ____/____/_______M D Y

2. Dose 2 given at least 28 days after first dose #2 ____/____/______ M D Y

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

a. Dose #1 ____/____/________ b. Dose #2 ____/____/________ M D Y M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____ M D Y

2. Date of most recent booster dose: ____/____/________ Type of booster: Td _____ Tdap ___

D. VARICELLA

a. Dose #1 ____/____/________ M D Y

b. Dose #2 given at least 12 weeks after first dose ages 1–12 year ____/____/________MDY

and at least 4 weeks after first dose if age 13 years or older.

Or History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

HEALTH CARE PROVIDER

Name ____

Address ____

Phone (__________)_________________________________

**By signing this form, I certify that this information is accurate*.

____ ___________________________

Legal Signature Date