THE COLLEGE of IDAHO

Immunization Record

The College of Idaho believes it is in the best interests of the Campus community for every student to be vaccinated appropriately. Listed below are the vaccination expectations of all students for the 2021-2022 school year. The College's entire Immunization Policy is located in the Student Handbook, including additionally recommended vaccinations, as well as the process for exemption.

PART I: General Information

Name ____

Address____

Street City State Zip

Date of Birth ____/____/________ School ID# _________________

Part II: COVID-19 Vaccination

The College of Idaho recognizes the efficacy of COVID-19 vaccinations in reducing the potential for infection, transmission, severe illness, and death. COVID-19 vaccines have met the U.S. Food and Drug Administration's rigorous scientific standards for safety and have been approved for Emergency Use Authorization. Moreover, they have proven to be remarkably safe over the period of their use, with over 294 million doses administered in the U.S. alone through May 2021. For these reasons, and in line with recommendations from the Centers for Disease Control, the College embraces the COVID-19 vaccine as the primary means for keeping our community safe and fully operational for the fall 2021 Semester.

Accordingly, effective Fall 2021, all students must adhere to one of the following:

1) Attest to having received one of the World Health Organization approved COVID-19 vaccinations.

Specify Vaccination Received, e.g., Pfizer, Moderna, Johnson & Johnson/Janssen, AstraZeneca, Serum Institute of India, or Sinopharm: ____

Dose #1 Date: ____/____/________ M/D/Y
Dose #2 Date: ____/____/________ M/D/Y (2nd dose is not necessary for the Johnson & Johnson/Janssen vaccination)

2) Obtain approval for a religious or medical exemption.

3) Consent to weekly COVID-19 PCR testing at personal expense, and reporting results to the Wellness Center.

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PART III: Required Vaccinations (Must be fully completed)

A. MMR (MEASLES, MUMPS, RUBELLA)

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

Dose #2 given at least 28 days after first dose #1 ____/____/______ M/D/Y

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

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

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

C. TETANUS, DIPHTHERIA, PERTUSSIS

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

Date of most recent booster dose: ____/____/________ M/D/Y

Type of booster: Td _____ Tdap ___

D. VARICELLA

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

Dose #2 given at least 12 weeks after first dose ages 1–12 year and at least 4 weeks after first dose if age 13 years or older ____/____/________M/D/Y

OR

Born before 1980 Yes ___ No ___

Part IV: Primary Health Care Provider

Name ____

Address ____

Phone (__________)____

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Part V: Signature (*By signing this form, I certify that this information is accurate, and knowingly providing false information could lead to disciplinary action, including suspension or expulsion from the College)*.

______________________________________ __________________________

Signature Date

If under 18 years of age:

______________________________________ __________________________

Legal Guardian Signature Date