



Bailey Health Center

IMMUNIZATION RECORD

Last Name, First Name: _____ L#: _____

Date of Birth: ____/____/____ Date of Entry: ____/____/____ Cell: (____) ____-____
M D Y M Y

THIS FORM MUST BE COMPLETED & SIGNED BY YOUR HEALTH CARE PROVIDER. ONCE COMPLETE FORMS CAN BE UPLOADED ONTO YOUR CHART USING THE UPLOAD OPTION ON THE STUDENT HEALTH PORTAL.

HEPATITIS B

Required

Three doses of vaccine OR two doses of adult vaccine in adolescents 11-15 years of age OR positive hepatitis B surface antibody

1. Immunization (hepatitis B) Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____ OR
2. Immunization (Combined hepatitis A and B vaccine)
Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____ OR
3. Hepatitis B surface antibody Date ____/____/____ Result: Reactive ____ Non-reactive ____

MENINGOCOCCAL B (Bexsero or Trumenba)

Required

This strain of meningitis is not covered by the traditional meningitis vaccine. Given as Bexsero **OR** Trumenba.

Trumenba Dose #1 ____/____/____ Dose #2 ____/____/____ OR
Two doses given 6 months apart

Bexsero Dose #1 ____/____/____ Dose #2 ____/____/____
Two doses given 30 days apart

MENINGOCOCCAL TETRAVALENT (MCV4)

Required

Dose #1 ____/____/____ Dose #2 (must be received after the age of 16) ____/____/____

MMR (Measles, Mumps, Rubella)

Required

Two doses required at least 28 days apart

Dose #1 ____/____/____ Dose #2 ____/____/____

POLIO

Required

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____ Dose #4 ____/____/____

TETANUS-DIPHTHERIA-PERTUSSIS

Required

Primary series with booster with Tdap in the last ten years. Date of last Tdap ____/____/____

VARICELLA (Chicken Pox)

Required

History of chicken pox, a positive varicella antibody, **OR** TWO doses of vaccine

1. History of Disease Yes _____ No _____ **OR**

2. Varicella antibody ____/____/____ Result: Reactive ____ Non-reactive ____ **OR**

3. Immunization

Two doses given at least 12 weeks after first dose if age 1-12 years and at least 4 weeks after first dose if age 13 years or older

Dose #1 ____/____/____ Dose #2 ____/____/____

COVID-19 VACCINE

Highly Recommended

	Pfizer	Moderna	J&J	Other
Dose #1				
Dose #2				

COVID BOOSTER

Highly Recommended

Dose #1 ____/____/____ Brand: Pfizer Moderna Other_____ (Circle one)

Dose #2 ____/____/____ Brand: Pfizer Moderna Other_____ (Circle one)

HEPATITIS A

Dose #1 ____/____/____ Dose #2 ____/____/____

HUMAN PAPILLOMAVIRUS VACCINE (Gardasil-9)

Two doses separated by 6 months for ages 9-14 **OR** three doses given at 0, 2 and 6 month intervals for ages 15 and up

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

TYPHOID ____/____/____

YELLOW FEVER ____/____/____

HEALTH CARE PROVIDER (must be signed by health care provider)

Name (print) _____ Address _____

Signature _____ Phone (____) _____ - _____

I am requesting a waiver for required immunizations for medical / religious reasons. I will complete and submit the waiver request form directly through the student portal.

Student Signature: _____ Date _____