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 (Serogroup A,C,W,Y) *Menactra, Menveo or Menomune*
Required

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

MENINGOCOCCAL B (Serogroup B) *Trumenba or Bexsero*
Required
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Trumenba Dose #1 _____/_____/_____ Dose #2 _____/_____/_____ OR
Two doses given 6 months apart

Bexsero Dose #1 _____/_____/_____ Dose #2 _____/_____/_____
Two doses given 6 months apart

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OR

MENINGOCOCCAL (Serogroup A,B,C,W,Y) *Penbraya*
This vaccine is a combination vaccine for both the Meningococcal vaccines listed above

Penbraya Dose#1____/_____/_____
One single dose followed by a single dose of Trumenba 6 months later

Trumenba Dose#1_____/_____/_____

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				
Dose #3				
Dose #4				

HEPATITIS A
Dose #1 _____/_____/_____
Dose #2_____/_____/_____

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*_____