Cadet Immunization Certificate

Term/Year of Enrollment: Fall Winter Spring Summer Year:_____

Name:_____
Last First Middle

Date of Birth:_____

Required Vaccines

(American College Health Association guidelines based on Advisory Committee on Immunization Practices published by the CDC)

MMR (Measles/Mumps/Rubella): **#1**_____ **#2**_____

or laboratory evidence of immunity Date: _____ Result:_____

Td or Tdap (Tetanus booster within past 10 years):_____

Varicella (Chickenpox): **#1:**_____ **#2:**_____

or history of disease Date:_____

or laboratory evidence of immunity Date:_____ Result:_____

Hepatitis B: **#1:**_____ **#2:**_____ **#3:**_____

or laboratory evidence of immunity Date:_____ Result:_____

Meningococcal (Meningitis):_____ or Signed waiver attached:_____

CERTIFICATION OF HEALTH CARE PROVIDER

Signature:_____

Printed Name: _____ Phone: _____

Address: _____