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: ____