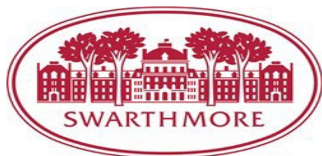
Last Name: ______________________________ First Name: ___________________________ Date of birth:_____________



Swarthmore College Immunization Record

To be completed and signed by a Health Care Professional. All information must be completed in English. You must attach immunization documents printed by your health care office. Once completed, this form along with all immunization records must be uploaded to your Student Health Portal. Dates of all immunizations must be entered on the portal.

The following vaccines are required:

A. COVID-19*, the primary vaccine series must be completed with the same vaccine.

1. Johnson & Johnson's Janssen – one dose Dose #1_____/_____/_____
2. Moderna - two doses separated by 28 days Dose #1_____/_____/_____ Dose #2_____/_____/_____
3. Pfizer-BioNTech - two doses separated by 21 days Dose #1_____/_____/_____ Dose #2_____/_____/_____
4. Sinopharm-VeroCell – two doses separated by 21 days Dose #1_____/_____/_____ Dose #2_____/_____/_____
5. AstraZeneca-CoviShield – two doses separated by 8-12 weeks Dose #1_____/_____/_____ Dose #2_____/_____/_____
6. Sinovac-Coronavac – two doses separated by 14 days Dose #1_____/_____/_____ Dose #2_____/_____/_____

COVID-19 BOOSTER, one dose of either Pfizer or Moderna COVID-19 vaccine is preferred. Alternatively, a Johnson & Johnson Janssen is accepted.
Name of booster vaccine: ____ Date given: ____________________
**If you received a COVID-19 vaccine after September 2023, a primary vaccine series is not required.*

B. HEPATITIS B

1. Immunization (hepatitis B)

Dose #1_____/_____/_____ Dose #2_____/_____/_____ Dose#3_____/_____/_____

Adult formulation____Child formulation____ Adult formulation____Child formulation____ Adult formulation____Child formulation____

OR

2. Immunization (Combined hepatitis A and B vaccinc)

Dose #1_____/_____/_____ Dose#2_____/_____/_____ Dose#3_____/_____/_____

OR

3. Hepatitis B surface antibody

Date_____/_____/_____ **Result**: Reactive______ Non-reactive

C. MEASLES, MUMPS, RUBELLA (MMR)
(Two doses requirement at least 28 days apart for students born after 1956)

1. Dose 1 given **after 12 months** of age. . . . . Dose#1_____/_____/_____
2. Dose 2 given **at least 28 days after** first dose . . . . Dose#2_____/_____/_____

D. MENINGITIS (MenACYW) **(One dose is required at age 16 or older)**

Dose#1_____/_____/_____ Dose#2_____/_____/_____

E. POLIO (Primary series, doses at least 28 days apart. Three primary series are acceptable See ACIP website for details)

1. OPV alone (oral Sabin three doses) Dose#1_____/_____/_____, Dose#2_____/_____/_____,Dose#3_____/_____/_____

OR

2. IPV/OPV sequential: IPV#1_____/_____/_____,IPV#2_____/_____/_____,OPV#3_____/_____/_____/,OPV#4_____/_____/_____

OR

3. IPV alone (injected Salk four doses: Dose#1_____/_____/_____,Dose#2_____/_____/_____,Dose#3_____/_____/_____,Dose#4_____/_____/_____

Last Name: ________________________________ First Name: _____________________________ Date of birth:______________

The following vaccines are <u>required</u>:

F. TETANUS-DIPHTHERIA-PERTUSSIS
(Primary series with DTaP, DTP, DT, or Td, First Tdap at 11 or 12 years of age or later and booster must be within the last ten years.)

1. Primary series of four doses with DTaP, DTP, DT, or Td:

Dose#1______/______/______, Dose#2______/______/______, Dose#3______/______/______, Dose#4______/______/______ **in addition to Tdap booster below**

2. Booster: within the last ten years

Tdap___/______/______

G. VARICELLA, note 2 dose requirement

Dose#1______/______/______, given **after 12 months** of age

Dose#2______/______/______ given at least 12 weeks after first dose ages 1-12 years and at least 4 weeks after the first dose if age 13 years or older

OR

History of Disease Yes______No______If so, when? _______________ **Health Care Professional signature**:____________________________________

The following vaccines are <u>strongly recommended</u>:

A. HEPATITIS A

a. Immunization (hepatitis A)

Dose#1______/______/______, Dose#2______/______/______

B. HUMAN PAPILLOMA VIRUS VACCINE (HPV)

Immunization (**indicate which preparation**, **if known)** **Quadrivalent (HPV4)________** **9-valent (HPV9)_______**

Dose#1______/______/______Dose#2___/_________/_________Dose #3_____/_______/________

C. INFLUENZA most recent dose _______/________/________

D. MENINGITIS B The vaccine series must be completed with the same vaccine.

1) MenB-RC (Bexsero) Dose#1______/______/_____, Dose #2_____/______/_____

2) MenB-FHbp (Trumenba) Dose#1_________/_________/_________Dose#2___/_________/_________Dose #3_____/_______/_______ ______

Health Care Professional

Please review all dates of immunizations and ensure the student has received them according to CDC/ACIP guidelines. If immunization was received off schedule, counsel student and consider additional vaccination. Please attach all immunization records to this form.

Signature: ____**Date:** __________________________

Printed Name: ____

Address: ____ **Phone:** __________________________