LOYOLA
UNIVERSITY MARYLAND

STUDENT HEALTH AND EDUCATION SERVICES

GRADUATE STUDENT IMMUNIZATION RECORD

4502A N. Charles St. Baltimore, MD 21210
410-617-5055 · FAX 410-617-2173

NAME LAST   FIRST   MIDDLE

☐☐–☐☐–☐☐   ☐ Male ☐ Female

BIRTHDATE (MONTH / DAY / YEAR)   SEX   STUDENT ID #   PHONE

HOME ADDRESS

CITY   STATE / COUNTRY IF APPLICABLE   ZIP

IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER. All information must be in English.

PREMATRICULATION REQUIREMENTS

A. **TDAP** (Tetanus-Diphtheria-Pertussis) .... ____/____/____ (MONTH DAY YEAR)

B. **POLIO** (OPV or IPV)

1. Completed primary series of polio immunization: ☐ Yes ☐ No .... Date of last booster ____/____/____ (MONTH DAY YEAR)

C. **MEASLES, MUMPS, RUBELLA** - ***Proof of Immunity Required***
MMR (Measles, Mumps, Rubella) – 2 doses required

1. Dose 1 – Immunized at 12 months after birth or later .... ____/____/____ (MONTH DAY YEAR)
2. Dose 2 – Immunized at any time 1 month after dose #1 .... ____/____/____ (MONTH DAY YEAR)

Or proof of immune titers ***(Attach)***

D. **TUBERCULOSIS** – ***Testing required for high-risk students only***

1. Tbc test within 6 months prior to admission
   Date, results, and measurement of induration if PPD (Mantoux) .... Date Adminstered ____/____/____ (MONTH DAY YEAR)
   Result: Negative_____ Positive_____ Complete mm results_____mm .... Date Read ____/____/____ (MONTH DAY YEAR)
2. Chest X-ray required if ≥10mm induration ***(Attach copy of chest X-ray report)***
   Date and result of chest X-ray .... Result: ☐ Normal ☐ Abnormal ____/____/____ (MONTH DAY YEAR)
3. Document any treatment (INH or other) received. If history of active TB, document completed TB therapy.
   (Attach copies of documentation)

E. **HEPATITIS B VACCINE** ____/____/____ (MONTH DAY YEAR)   ____/____/____ (MONTH DAY YEAR)   ____/____/____ (MONTH DAY YEAR)

F. **VARICELLA** (chickenpox)

1. Had disease, confirmed by office record .... ____/____/____ (MONTH DAY YEAR)
2. Has report of positive immune titer, specify date .... ____/____/____ (MONTH DAY YEAR)
3. Varicella vaccine .... ____/____/____ (MONTH DAY YEAR)

HEALTH CARE PROVIDER

NAME

ADDRESS   CITY   STATE   ZIP

SIGNATURE   TELEPHONE   DATE

PRINT NAME