Immunization Records

Required Immunizations

**** Please attach an official copy (high school transcript, health department, medical provider) of the following immunizations to this health form. If an official copy is not provided then the Physician MUST sign to certify immunization dates****

Measles, Mumps, Rubella MMR	**Dose #1: Date** ___/___/___ MM DD YY	**Dose #2: Date** ___/___/___ MM DD YY	**OR Titer (Attach Copy)**	
Poliomyelitis (OPV) or (IPV)	**Dose #1: Date** ___/___/___ MM DD YY	**Dose #2: Date** ___/___/___ MM DD YY	**Dose #3: Date** ___/___/___ MM DD YY	**Dose #4: Date** ___/___/___ MM DD YY
Hepatitis B	**Dose #1: Date** ___/___/___ MM DD YY	**Dose #2: Date** ___/___/___ MM DD YY	**Dose #3: Date** ___/___/___ MM DD YY	**OR Titer: (Attach Copy)**
Diphtheria/Pertussis/ Tetanus (Tdap) MUST be within 10 years	**Date:** ___/___/___ MM DD YY			
Covid -19 Vaccine Moderna______ Pfizer_________ J&J ________	**Dose #1: Date** ___/___/___ MM DD YY	**Dose #2: Date** ___/___/___ MM DD YY	**Booster If applicable Date:** ___/___/___ MM DD YY	

Strongly Recommended Immunizations but not required

Meningococcal Vaccine	**Dose #1: Date** _____/_____/_____ **MM DD YY**	**Dose #1: Date** _____/_____/_____ **MM DD YY**	**Dose #1: Date** _____/_____/_____ **MM DD YY**
HPV	**Dose #1: Date** _____/_____/_____ **MM DD YY**	**Dose #1: Date** _____/_____/_____ **MM DD YY**	**Dose #1: Date** _____/_____/_____ **MM DD YY**
Varicella Vaccine	**Dose #1: Date** _____/_____/_____ **MM DD YY**	**Dose #2: Date** _____/_____/_____ **MM DD YY**	**Or documented date of Chicken Pox disease** _____/_____/_____ ****Or attach titer if one was done**

Meningitis Vaccine Waiver (Student must sign if vaccine was not received)

The Code of Virginia (Chapter 340 23-7.5) requires that "each full-time student shall be vaccinated against Meningococcal (Meningitis) unless the student or, if the student is a minor, the student's parent or legal guardian signs a written waiver stating that he or she has received and reviewed detailed information on the risks associated with Meningococcal (Meningitis) and the availability and effectiveness of any vaccine and has chosen not to be or not to have the student vaccinated."

I have read the Frequently Asked Questions at *https://www.cdc.gov/meningococcal/about/index.html*, and reviewed the Averett University Statement on Recommended Immunizations available at www.averett.edu. I understand the risks associated with the disease, including the effectiveness and availability of any vaccine against Meningococcal, and decline to receive the immunization.

Student's signature for waiver____Date ________________

Physician verification of vaccine records if official copy is not attached:

Healthcare Provider's Signature________________________________MD/NP Date ___________________

Provider's Name Printed_______________________________ Phone Number: _________________________________

Address ____