University of Richmond Student Health Center
490 Westhampton Way, University of Richmond, VA 23173
(804-289-8064) healthcenter.richmond.edu

IMMUNIZATION RECORD

TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Due June 1 for Fall entry, January 1 for Spring entry

Name: ____ **URID:** ____________________ **Date of Birth:** _____________________

Virginia State Law and the University of Richmond Require the Following Immunizations

1) MMR (Measles, Mumps, Rubella) → Dose #1 (MM/DD/YYYY)____/______/_______

Two doses live vaccine required at or after 12 months of age, at least one month apart → Dose #2 (MM/DD/YYYY)____/______/_______

Use ONLY If vaccinated separately:

Measles: Dose #1_____/____/_____Dose #2________/____/______ **Mumps:** Dose #1_____/____/_____ Dose #2____/____/______

Rubella: Dose #1_____/____/_____

Use ONLY If titers were drawn:

Measles Titer Date: (MM/DD/YYYY) ____/____/____ Result:__________ **Mumps Titer Date:** (MM/DD/YYYY) ____/____/____ Result: ________

Rubella Titer Date: (MM/DD/YYYY) ____/____/____ Result: ________

2) Tdap (TETANUS/DIPHTHERIA/PERTUSSIS): (MM/DD/YYYY) ____/____/____ (If vaccine date is older than 10 years, revaccinate.)

OR

Td (TETANUS/DIPTHERIA): (MM/YY/YYYY) ____/____/____ (If vaccine date is older than 10 years. revaccinate)

3) MENINGOCOCCAL MCV VACCINE: (MM/DD/YYYY) _____/____________/______ (Vaccine date **must be** **after** student turned 16. If not, revaccinate or sign waiver on web portal.)

OR

MENINGOCOCCAL MPSV VACCINE: (MM/DD/YYY) _____/_____/_____

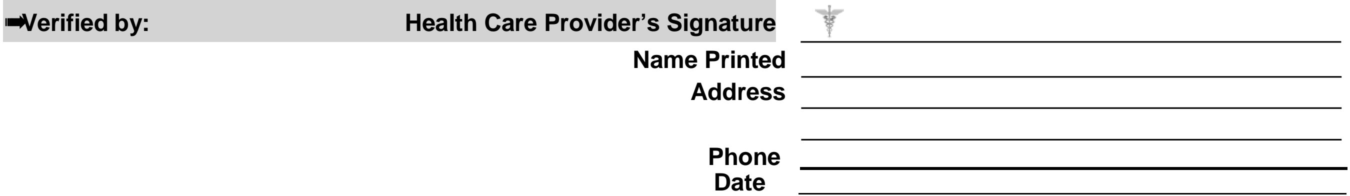
4) HEPATITIS B VACCINE: (3 doses required or sign waiver on web portal)

Dose #1: (MM/DD/YYYY) ____/____/____
Dose #2: (MM/DD/YYYY) _____/____/____
Dose #3: (MM/DD/YYYY) ____/____/____

5) POLIO OPV VACCINE: (Last dose must be given after 4th birthday. If last dose given prior to 4th birthday, on web portal) Last Dose Date: (MM/DD/YYYY) ____/____/____

OR

POLIO IPV VACCINE: (Last dose must be given after 4th birthday. If last dose given prior to 4th birthday, sign waiver on we Last Dose Date: (MM/DD/YYYY) ____/____/____



➡Verified by: **Health Care Provider's Signature** ________________________________

Name Printed ________________________________

Address ________________________________
____

Phone ________________________________

Date ________________________________

RECOMMENDED IMMUNIZATIONS (NOT Required for Admission)

Name: ______________________________________ URID: ___________________ Date of Birth: ____________________

A. VARICELLA VACCINE: Dose #1(MM/DD/YYYY):____/____/____ Dose #2(MM/DD/YYYY):____/____/____

OR Date of documented disease: Month____/Year____

B. HEPATITIS A VACCINE (*2 doses vaccine given at 0, 6-12 months)* Dose #1(MM/DD/YYYY):___/____/____Dose #2(MM/DD/YYYY):____/____/____

C. HPV 4 (HUMAN PAPILLOMAVIRUS VACCINE): (*3 doses at 0, 2, and 6 month intervals)*

Dose #1 :(MM/DD/YYYY) ___/____/____Dose #2 :(MM/DD/YYYY) ____/____/____ Dose #3 :(MM/DD/YYYY) ___/____/___

D. HPV 9 (HUMAN PAPILLOMAVIRUS VACCINE): (*3 doses at 0, 2, and 6 month intervals)*

Dose #1 :(MM/DD/YYYY) ___/____/____Dose #2 :(MM/DD/YYYY) ____/____/____ Dose #3 :(MM/DD/YYYY) ___/____/___

E. Trumenba or Bexsero (MENINGOCOCCAL B NOS VACCINE)

Dose #1 :(MM/DD/YYYY) ___/____/____Dose #2 :(MM/DD/YYYY) ____/____/____ Dose #3 :(MM/DD/YYYY) ___/____/___

F. PNEUMOCOCCAL VACCINE PCV MM/DD/YYYY ____/____/____

G .PNEUMOCOCCAL VACCINE PPSV MM/DD/YYYY ____/____/____

Verified by: Health Care Provider's Signature

Name Printed ______________________________________

Address ______________________________________

____

Phone ______________________________________

Date ______________________________________