# ADVENTIST UNIVERSITY OF HEALTH SCIENCES

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STUDENT IMMUNIZATION FORM

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**Statement of Understanding**
Students must meet the immunization requirements of their selected professional program. Program requirements can be found in the Adventist University Academic Bulletin.

I have read and understand the immunization requirements of the professional program of which I am interested in. Furthermore, I understand failure to receive proper immunizations will prohibit my progression in said program.

_____
**Student Signature**

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**Directions:**

1. Your Healthcare Provider must complete **sections A - C**
2. You must return this form to the Health and Biomedical department **before** you may register for classes.

**Name: _____ Student ID #: _____ Birth date: ____/___/_____**

## SECTION A - REQUIRED OF ALL STUDENTS

**TUBERCULOSIS**

DATE PPD Administered: _____ DATE PPD Read: _____ Results: _____ or CXR: _____

Follow-up: _____

**MEASLES (Rubeola), MUMPS & German Measles (Rubella) - Must have one of the following**:

a. Proof of two (2) MMR Immunizations at least 30 days apart. Dates: _____ _____, and /or

b. Proof of Positive Titer for MMR:

Measles: _____ _____ ; Mumps:_____ _____ ; Rubella:_____ __ _____
Titer Date Titer Results Titer Date Titer Results Titer Date Titer Results

**TETANUS-DIPHTHERIA**

Primary Series _____, and/ or Booster within the last ten (10) years _____
Date completed Date of Booster

**VARICELLA ZOSTER VIRUS ( Chicken Pox)- Documentation will be accepted only as follows**:

a. Proof of two (2) VZV Immunizations at least four weeks apart. Date: _____ _____, and/or

b. Proof of positive Titer for VZV: _____ _____ **COPY OF RESULTS IS REQUIRED**
Titer Date Titer Results

c. History of varicella: verbal or written documentation (**circle one**)

**HEPATITIS B**- (3 SHOTS) Dates:_____ _____ _____

**Hepatitis Declination:** I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccination at this time. I understand that by declining or not completing the series of this vaccine, I continue to be at risk for acquiring Hepatitis B, a serious disease. Signature of student or legal guardian (if student under 18)

_____ _____
Signature (if declining) Date Witness Date

## SECTION B - REQUIRED OF ALL HOUSING STUDENTS

**Menomune/Menactra (meningococcal meningitis)**
Vaccination Date:_____ or Read attached information sheet and Sign Waiver Below

**Meningococcal Meningitis Declination:** I have read the information provided and I decline receipt of vaccine for meningococcal meningitis.
Signature of student or legal guardian (if student under 18)

_____ _____
Signature (if declining) Date Witness Date

## SECTION C - HEALTH CARE PROVIDER USE ONLY

**A. I hereby certify that _____ has been vaccinated for each of the listed diseases on the recorded dates.**

**B. Practitioner's Signature** _____ **Print Name**_____
**License Number** _____ **Licensed as: Physician**
**State/County Licensed** _____ **(circle one) Physician's Assistant**
**ARNP**

**All documentation is subject to approval by Adventist University of Health Sciences**