WPI Health and Wellness Services
Immunization Record

Name: ____ Date of Birth: ______________ Student ID#:______________________

Cell Phone: ________________________ Email: ____________________________________ Gender: ☐ Male ☐ Female

Required Vaccines					
Vaccine	**Date 1**	**Date 2**	**Date 3**	**Date 4**	**Date 5**
MMR (2) OR					
Measles Titer *		☐ Immune ☐ Not Immune			
Mumps Titer *		☐ Immune ☐ Not Immune			
Rubella Titer *		☐ Immune ☐ Not Immune			
Hepatitis B (3) OR				☐ 2 dose series (adolescent)	
Hepatitis B Titer* (HBsAB)		☐ Immune ☐ Not Immune			
Meningitis		☐ Signed Waiver			
Tdap					
Varicella (2) OR					
Varicella Titer * **OR**		☐ Immune ☐ Not Immune			
History of Varicella Disease					
TB test - PPD or IGRA if high risk		PPD _____ mm IGRA ☐ + ☐ -	IF + Chest X-ray date ___________	Chest X-ray result __________	Prophylactic Med completed ______

***Attach laboratory report of all titers**.

Recommended Vaccines					
Vaccine	**Date 1**	**Date 2**	**Date 3**	**Date 4**	**Date 5**
HPV vaccine					
Hepatitis A					
Pneumococcal					

Healthcare provider: ____
Please print Last First NP, PA, MD, DO

Address____

Phone #: ______________________________________ Fax #: ____________________________________

Signature of Healthcare provider:____ Date: __________________________