UNIVERSITY OF JUSTICE

Student Immunization & Vaccination Record

Last Name	First Name	M.I.	Date of Birth (MM/DD/YYYY)

Street Address	City

State	ZIP Code	Cell Phone

Student ID	Medical School (if applicable)	Primary Email

1. MMR (MEASLES, MUMPS, RUBELLA)

Choose ONLY one option. Attach a copy of lab results if using serologic proof.

Option 1: Two doses of MMR Vaccine		
Vaccine	**Dose #1 Date**	**Dose #2 Date**
MMR (Combined)		
Option 2: Individual Vaccine Doses or Serologic Immunity (Titer)		
Disease	**Vaccine Dates**	**Serology (Titer) Results**
Measles	Dose 1: Dose 2:	Date: Qualitative: [ ] Pos [ ] Neg Quantitative: _____ IU/ml
Mumps	Dose 1: Dose 2:	Date: Qualitative: [ ] Pos [ ] Neg Quantitative: _____ IU/ml
Rubella	Dose 1:	Date: Qualitative: [ ] Pos [ ] Neg Quantitative: _____ IU/ml

2. TETANUS-DIPHTHERIA-PERTUSSIS

One dose of adult Tdap. If >10 years old, provide Td booster.

Type	Date Administered
Tdap (Adult)	
Td (Booster)	

3. VARICELLA (CHICKEN POX)

2 doses of vaccine or positive titer results.

Dose #1 Date	
Dose #2 Date	
Titer (Date/Res)	Date: [ ] Pos [ ] Neg

4. INFLUENZA VACCINE

1 dose annually each fall.

Flu Vaccine Date	

5. COVID-19 VACCINE

Updated 2025-2026 formulation.

Product Name (Pfizer/Moderna/Novavax)	Date

6. HEPATITIS B VACCINATION & IMMUNITY

3 doses (Engerix-B/Recombivax) OR 2 doses (Heplisav-B) AND a Quantitative Surface Antibody test (>10mIU/mL).

Primary Series	3-Dose Series (Dates)	2-Dose Series (Heplisav)
Dose #1 Date		
Dose #2 Date		
Dose #3 Date		N/A
QUANTITATIVE Titer Result (Drawn 4-8 weeks post-series)	Date: Value: _____ mIU/ml [ ] Positive (>10) [ ] Negative	

If No Response to Primary Series (Non-Responders)

Dose #4 Date	Dose #5 Date	Dose #6 Date	Repeat QUANTITATIVE Titer
			Date: Value: _____ mIU/ml

☐ **Non-Responder Status:** Titer remains <10 mIU/mL after two complete series. Counseling received.

7. ADDITIONAL DOCUMENTATION

Specific university program requirements (e.g., Meningitis, Physical Exams).

Vaccination, Test, or Exam Type	Date	Result or Interpretation
Meningitis (MenACWY)		
Physical Examination (if required)		
Other (Yellow Fever, Typhoid, etc.)		

8. TUBERCULOSIS (TB) SCREENING

Required regardless of prior BCG status. Complete only ONE section (A or B).

Section A: History of Negative TB Skin Test (TST) or Blood Test (IGRA)

Step	Date Placed	Date Read	Result (mm)	Interpretation
TST Dose #1				[ ] Pos [ ] Neg [ ] Equiv
TST Dose #2 (or annual)				[ ] Pos [ ] Neg [ ] Equiv

OR Blood Test (IGRA): QuantiFERON Gold or T-Spot (U.S. performed within 12 months)

Date	Method	Result
	[ ] QuantiFERON [ ] T-Spot	[ ] Pos [ ] Neg [ ] Indeterminate

Section B: History of Positive TST (>10mm) or IGRA Blood Test

Type of Result	Date	Details/Results
Initial Positive TST/IGRA		Result: _____ mm
Chest X-Ray (CXR)		[ ] Normal [ ] Abnormal (Attach Report)
LTBI Treatment?	[ ] No [ ] Yes - Meds: _____ Duration: _____	
Last Annual Questionnaire		Result: No current symptoms

Licensed Healthcare Professional Certification

I certify that I have reviewed this student's records and the above information is accurate and matches clinical documentation.

Healthcare Professional Signature	Date Signed

Printed Name & Title	License Type/Specialty

Office Address Line 1	Phone Number

City, State, Zip	Office Fax

FOR UNIVERSITY OFFICE USE ONLY

Status	Reviewer Initials	Date Processed
[ ] Complete [ ] Missing Info [ ] Denied		

*Sources: CDC Epidemiology and Prevention of Vaccine-Preventable Diseases, 13th Ed; ACIP Recommendations Vol 60(7):1-45; CDC/NTCA Tuberculosis Screening 2019.