VMI IMMUNIZATION RECORD

******This form must be *completed* and signed by the applicant's physician.******

Applicant's Name: _____ Date of Birth: ___/___/___

The following immunizations are required for enrollment at VMI.

Please do not submit health department, school health or copies of physician's office immunization records.

1. Diphtheria-Tetanus: **(Mandatory)**
   (Booster should include Pertussis)

   Date of completion of primary series ___/___/___
   Exact date of last booster___/___/___ **(Must be within 6 years of matriculation)**

2. Poliomyelitis: **(Mandatory)**

   Date of completion of primary series ___/___/___
   Date of last booster ___/___/___

3. Measles-Mumps-Rubella (MMR): **(Mandatory)**
   TWO IMMUNIZATIONS REQUIRED. THE FIRST ONE **AFTER THE FIRST BIRTHDAY**; THE SECOND ONE **NO SOONER THAN ONE MONTH LATER OR ANY TIME THEREAFTER.**

   Date of 1st dose ___/___/___
   Date of 2nd dose ___/___/___

4. Hepatitis B: **(Mandatory)**

   Date of 1st dose ___/___/___
   Date of 2nd dose ___/___/___
   Date of 3rd dose ___/___/___

5. Meningococcal Vaccine: **(Mandatory)**

   Date ___/___/___

6. Chicken Pox (had disease) Yes___No___ or Immunization Dates Date of 1st dose ___/___/___
   (2 Doses are mandatory if no disease) Date of 2nd dose___/___/___

7. Tuberculin Test: (Required for applicants who have lived or traveled extensively overseas)

   Date ___/___/___ NEGATIVE _____
   POSITIVE _____ (mm induration: _____)

   CHEST XRAY RESULTS: (only if POSITIVE) _____
   Treatment? _____

HPV (QUADRIVALENT HUMAN PAPILLOMAVIRUS VACCINE) **(Recommended for female applicants)**
Three doses of vaccine for female applicants at 0, 2, and 6 month intervals.

Date of 1st dose ___/___/___
Date of 2nd dose ___/___/___
Date of 3rd dose ___/___/___

_____
Physician's Signature

_____
Printed Name

_____
City, State Zip Code

_____ _____
Date Area Code & Phone Number