VIRGINIA MILITARY INSTITUTE

IMMUNIZATION RECORD

This form must be **completed and signed** by the applicant's health care provider.

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

REQUIRED: The following immunizations are required for enrollment at VMI.

1. Diphtheria-Tetanus (DTP): **(Mandatory)**
   Date of completion of childhood series ___/___/___

2. Hepatitis B: **(Mandatory)**
   Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___ Date of 3rd dose ___/___/___

3. Meningococcal conjugate or MenACWY vaccines (Menveo®, MenQuadfi®, Penbraya® or PENMENVY®):
   (Mandatory – One dose after age 16 required)
   Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___

4. 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 ___/___/___

5. Poliomyelitis: **(Mandatory)**
   Date of completion of primary series ___/___/___

6. Tdap Booster: **(Mandatory)**
   Date of last booster___/___/___ **(Must be within 10 years of matriculation)**

7. Chicken Pox (had disease) Yes__No__ or Immunization Dates Date of 1st dose___/___/___
   (2 doses mandatory if no disease) Date of 2nd dose___/___/___

8. Tuberculin Test: (**Required for applicants who have lived or traveled extensively overseas)**
   Date___/___/___ Result: (mm induration: _____)
   CHEST XRAY RESULTS: (only if POSITIVE) _____
   Treatment? _____

RECOMMENDED: The following immunizations are recommended.
If you have not had these vaccines, ask your provider why.

COVID-19 (Highly Recommended)
Indicate which vaccine ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other specify _____
Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___ Date of Booster ___/___/___

Hepatitis A (Recommended)
Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___

HPV (HUMAN PAPILLOMAVIRUS VACCINE) (Highly Recommended)
Applicant had the 2 dose OR 3 dose series
Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___ Date of 3rd dose ___/___/___

Meningococcal B or Serogroup B meningococcal vaccines (Bexsero®, Trumenba®, Penbraya® or PENMENVY®)

Discuss with your provider Applicant had the 2 dose OR 3 does series
Date of 1st dose ___/___/___ Date of 2nd dose ___/___/___ Date of 3rd dose ___/___/___

Health Care Provider's Signature	**Printed Name**	**Date**
City, State, Zip Code	**Area Code & Phone Number**	