
PURDUE UNIVERSITY STUDENT HEALTH CENTER

IMMUNIZATION HISTORY FORM

1. Please PRINT- This form must be completed in English using MM/DD/YY format
 2. Form must be signed by a provider
 3. Upload in Medical Clearances tab of Patient Portal (Immunization Record- MC)
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Last Name: _____ First Name: _____

Purdue ID#: _____ Date of Birth: _____

A. Tetanus/Diphtheria (**Must be within last 10 years**)

Td: ___/___/___ OR Tdap: ___/___/___

B. MMR (Measles, Mumps, Rubella) (**Must be on or after 1st birthday**)

MMR Dose 1: ___/___/___ MMR Dose 2: ___/___/___

OR

Measles Dose 1: ___/___/___ Measles Dose 2: ___/___/___

Mumps Dose 1: ___/___/___ Mumps Dose 2: ___/___/___

Rubella Dose 1: ___/___/___ Rubella Dose 2: ___/___/___

C. Meningococcal Quadrivalent (**Must be on or after 16th birthday**)

Only required for students 23 or younger

Most Recent Dose: ___/___/___

D. Meningococcal B (**2 doses of same brand**)

Only required for students 23 or younger

Bexsero (OMV) Dose 1: ___/___/___ Bexsero (OMV) Dose 2: ___/___/___

OR

Trumenba Dose 1: ___/___/___ Trumenba Dose 2: ___/___/___

Provider Signature Required
(MD, DO, NP, RN)

Date