

PART I – To be completed by student

Last Name (Please Print)	First	Middle Initial	For office use only: Student Identification Number	
Date of Birth (Mo.Day/Yr)	Sex	Home Telephone	<input type="checkbox"/> ← Fall <input type="checkbox"/> → Winter <input type="checkbox"/> ← Spring/Summer <input type="checkbox"/> → Year	Quarter Attending (Check One)

Please Read Instructions on Reverse Side Carefully

PART II – To be completed and signed by Health Care Provider(s)*. ALL DATES MUST INCLUDE MONTH AND YEAR.

- ***MEASLES (Rubeola)**: (At least one of the following **must** be documented). () Dates of immunization 1. _____
1. a) **First** immunization with live attenuated virus. (Given at least 30 days after first immunization) after student's first birthday.
 - b) **Second** immunization with live attenuated virus. (Given at least 30 days after first immunization). () Dates of immunization 2. _____
 2. Immunity confirmed by blood titer. (**Must** attach copy of laboratory test in English). () Dates of test _____
 3. Disease confirmed by Physician's records. () Dates of illness _____
- * **GERMAN MEASLES (Rubella)**: (At least one of the following **must** be documented)
1. Immunization with live attenuated virus. (Given after 1967 or later and given on or after student's first birthday). () Dates of immunization _____
 2. Immunity confirmed by blood titer. (**Must** attach copy of laboratory test in English). () Dates of test _____
- * **MUMPS**: (At least one of the following **must** be documented)
1. Immunization with live attenuated virus. (Given after 1967 or later and given on or after student's first birthday). () Dates of immunization _____
 2. Immunity confirmed by blood titer. (**Must** attach copy of laboratory test in English). () Dates of test _____
 3. Disease confirmed by Physician's records. () Dates of illness _____
- * **TETANUS/DIPHTHERIA**:
1. Primary series completed. (At least 2 dose dates required for international students). () Date of immunization _____
() Date of immunization _____
 2. Most recent tetanus booster. (Within last 10 years for ALL STUDENTS) () Date of immunization _____

Provider Signature(s) _____	
Provider Name(s) (Please Print) _____	
Address(es) _____	City/State/Zip _____

*"Provider" = Physician licensed to practice medicine in all of its branches (M.D. or D.O.), or Licensed Nurse, or a Public Health Official

FOR OFFICE USE ONLY:				
Reviewed by _____	Date _____	() Complete	() Incomplete	
	Measles (Rubeola)	German Measles (Rubella)	Mumps	Tetanus/Diphtheria
Immune:	()	()	()	()
Except:	()	()	()	()
Outstanding:	()	()	()	()