DORDT
STUDENT HEALTH AND COUNSELING CENTER

Immunization Record 2024-2025

Student Health & Counseling
700 7th St NE, Sioux Center, IA 51250
Ph: 712-722-6990

To return form Student must log in to www. Dordt.medicatconnect.com and upload.

Name_____Date of Birth_____/_____/_____
Last First Middle

Address_____
Street City State Zip Code Country

Required Immunizations					
MMR (Measles, Mumps, Rubella) 2 doses required of individuals or vaccines as listed below	Date of dose #1: Must be 12 months after birth or later	Date of dose #2: Must be at least 1 month after First dose			
Measles (Rubeola) Students born prior to 1957 are required to have at least one dose	Date of dose #1: Must be 12 months after birth of later	Date of dose #2: Must be at least 1 month after first dose	*Or* Record of Titer- attach lab results ☐Positive ☐ Negative Date:		
Mumps Required for all students regardless of age	Date of dose #1: Must be 12 months after birth of later	Dose #2: Must be at least 1 month after first dose	*Or* Record of Titer – attach lab results ☐Positive ☐ Negative Date:		
Rubella (German Measles) Required for all students regardless of age	Date of dose #1: Must be 12 months after birth or later		*Or* Record of Titer – attach lab results ☐ Positive ☐ Negative Date:		
***Denotes Requirements for Nursing Majors** **Additional Recommended Immunizations for Non-Nursing Majors**					
Covid-19	Date of dose #1: ☐ Pfizer ☐ Moderna ☐ Johnson&Johnson	Date of dose #2: ☐ Pfizer ☐ Moderna	Date of Booster: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson		
Hepititis A	Date of dose #1:	Date of dose #2:			
Hepatitis B ***Required for Nursing**					
Enqerix B or Recombivax (3 dose series)	Date of dose #1:	Date of dose #2:	Date of dose #3:		
Or Hepatitis B (2 dose series) *Heplisav-B*	Date of dose #1:	Date of dose #2:			
Or Hepatitis B Titer	☐ Positive ☐ Negative Attach lab results	Date of Titer:			
HPV	Date of dose #1:	Date of dose #2:	Date of dose #3:		
Meningococcal Vaccine (A,C,Y,W-135) At least one dose required between 16 and 22 years.	☐ Menactra ☐ Menomune ☐ Menveo ☐ Other:	Date of dose:	Date of Booster:		
Meningococcal B Vaccine (Trumenba or Bexero)	Date of dose #1: ☐ Trumenba ☐ Bexero	Date of dose #2: ☐ Trumenba ☐ Bexero	Date of dose #3: ☐ Trumenba		
Polio *Required for Nursing	Dates: Dose #1:	Dose #2:	Dose #3:	Dose #4:	Dose #5:
Tetnus/Diptheria/Pertussis – Students must have at least 3 doses; one of which must be a Tdap booster and one of which must be within the past 10 years. ***Required for Nursing**					
DTP, DTaP, or Td	Date of dose #1	Date of dose #2	Date of dose #3	Date of dose #4	
Tdap booster **must have one documented within the last 10 years					
Varicella (Chicken Pox) ***Required for Nursing** 2 doses required or positive titer	Date of dose #1: Must be 12 months after birth or later Date of dose #2:	*Or* Record of Titer – attach lab report ☐ Positive ☐ Negative Date:	Documented History of disease (non-nursing students only)		
Tuberculin Screening – IGRA Blood Test (preferred) OR a 2-step TB skin test (TST) placed within the past 12 months. ***Required for Nursing. All testing must be done in the U.S. or Canada.**					
2 Step TST – placed within the past 12 months. The 2nd TST must be placed at least 1 week AFTER the 1st read date and no later than 12 months after TST 1.	1st TST Place Date	1st TST Read Date	2nd TST Place Date	2nd TST Read Date	
OR					
	Date of IGRA	Result			

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*IGRA TB Screening *must attach laboratory results* ☐ T-spot ☐ QuantiFERON Gold			
Influenza Vaccine ***After freshman year, an annual dose is required for all Nursing students.**			
Date:			
Additional Immunizations			
Typhoid	Date:	☐ Oral ☐ Injectable	
Other (Pneumovax, Yellow Fever, Japanese Encephalitis)			

Signature of Health Care Provider: _____ Date: _____
(MD, DO, PA, NP, RN – Not immediate family member)

Physician/Medical Provider Name: (Please Print) _____

Address:

_____

Phone Number: _____ Fax Number: _____

Clinic Stamp: