DORDT STUDENT HEALTH AND COUNSELING CENTER

Immunization Record 2022-2023

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:

*Requirements for Nursing Majors Additional Recommended Immunizations for Non-Nursing Majors					
Covid-19 ***Required for Nursing**	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				
*IGRA TB Screening *must attach laboratory results* ☐ T-spot ☐ QuantiFERON Gold	Date of IGRA	Result		

Influenza Vaccine ***Required for Nursing: must be completed prior to enrolling for spring semester**				
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: