DORDT
STUDENT HEALTH AND COUNSELING CENTER

Immunization Record 2020-2021

Student Health & Counseling
700 7th St NE, Sioux Center, IA 51250
Ph: 712-722-6990
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To return form, log in and upload at:
https://dordt.medicatconnect.com/

Name_____ Date of Birth_____/_____/_____
Last First Middle

Address_____
Street City State Zip Code Country

Required Immunizations			
MMR (Measles, Mumps, Rubella) 2 doses required or individual vaccines as listed below	Date of dose #1: Must be 12 months after birth or later	Date of dose #2: Must be at least 4 weeks after First dose	
Measles (Rubeola) if no MMR: Students born prior to 1957 are required to have at least one dose	Date of dose #1:	Date of dose #2:	*Or* Record of Titer- attach report ☐Positive ☐ Negative Date:
Mumps (if no MMR) 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 4 weeks after first dose	*Or* Record of Titer – attach report ☐Positive ☐ Negative Date:
Rubella/German Measles (if no MMR): Required for all students regardless of age	Date of dose #1: Must be 12 months after birth or later	Date of dose #2: Must be at least 4 weeks after the first dose	*Or* Record of Titer – attach report ☐ Positive ☐ Negative Date:
Meningococcal Vaccine (A,C,Y,W-135) At least one dose required between the ages of 16 and 22 years	☐ Menactra ☐ Menomune ☐ Menveo ☐ Other:	Date of dose:	Date of booster dose:
Tdap (Tetanus-Diptheria-Pertussis) one dose after age 11.	Date of Tdap dose:	If Tdap given > 10 years ago then Tetanus-Diptheria required (Td)	Date of Td dose:
Recommended Immunizations and Additional Requirements for Nursing Majors			
Varicella (Chicken Pox) History of disease or 2 doses required or positive titer ***Required for Nursing**	Date of dose #1: Must be 12 months after birth or later Date of dose #2:	*Or* History of Disease Date:	*Or* Record of Titer – attach report ☐ Positive ☐ Negative Date:
Hepatitis B (3 dose series) ***Required for Nursing**	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 report	Date of Titer:	
Hepatitis A	Date of dose #1:	Date of dose #2:	
HPV	Date of dose #1:	Date of dose #2:	Date of dose #3:
Meningococcal B Vaccine (Trumenba or Bexero)	Date of dose #1: ☐ Trumenba ☐ Bexero	Date of dose #2: ☐ Trumenba ☐ Bexero	Date of dose #3: ☐ Trumenba
Polio (most recent booster)	Date:		
Additional Immunizations			
Rabies	Date of dose #1:	Date of dose #2:	Date of dose #3:
Typhoid	Date:	☐ Oral ☐ Injectable	
Other (Flu, 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: