

**IUPUI HEALTH SERVICES**  
**Student - Immunization Record**  
Please complete this form in its entirety.

NAME \_\_\_\_\_ ID# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Please Print

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ If student what, is your major / program \_\_\_\_\_

1) **Rubella** [German Measles]  
Must have proof of one dose  
of vaccine or a positive titer.

Immunization Date \_\_\_\_\_  
Titer Date \_\_\_\_\_ Titer Results \_\_\_\_\_

2) **Rubeola** [Measles]  
Must have proof of 2 measles  
vaccines **OR** a positive titer **OR**  
documented disease by a physician.

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Titer Date \_\_\_\_\_ Titer Results \_\_\_\_\_

3) **Mumps**  
Must have proof of vaccine **OR**  
positive titer.

Immunization Date \_\_\_\_\_  
Titer Date \_\_\_\_\_ Titer Results \_\_\_\_\_

4) **PPD Screening** [TB Test]

Step 1 date placed \_\_\_\_\_ Date read \_\_\_\_\_  
Results \_\_\_\_\_  
Chest x-ray f/u date \_\_\_\_\_ Results \_\_\_\_\_  
Step 2 date placed \_\_\_\_\_ Date read \_\_\_\_\_  
Results \_\_\_\_\_  
Chest x-ray f/u date \_\_\_\_\_ Results \_\_\_\_\_

5) **Hepatitis B** vaccine series

Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Dose #3 \_\_\_\_\_

**Hepatitis B Titer**

HbsAb Results \_\_\_\_\_ Date \_\_\_\_\_

6) **Tetanus** vaccine  
Within the past 10 years.

Date \_\_\_\_\_

7) **Chicken Pox**  
Must have had the disease **OR** have  
had 2 doses of the varacella vaccine  
**OR** have proof of a positive titer.

Date you had disease \_\_\_\_\_  
Dose #1 \_\_\_\_\_ Dose #2 \_\_\_\_\_  
Titer Date \_\_\_\_\_ Titer Results \_\_\_\_\_

**Altered forms or forms with missing or incomplete information will not be accepted.**