WALSH UNIVERSITY
EDUCATION FOR LIFE
Counseling Services
330.490.7348

WALSH UNIVERSITY
2020 East Maple Street
North Canton, OH 44720

IMMUNIZATION RECORD

PART I: Student Information

Last Name	First Name	Middle Name
Address		
City	State	Zip
Phone Number	Email	
Date ____/_____ M Y	Date of Birth ____/____/_____ M D Y	Walsh ID#

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose 1 given at age 12 months or later — #1 ____/____/_____ M D Y
2. Dose 2 given at least 28 days after first dose — #2 ____/____/_____ M D Y

B. MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).
   a. Dose #1 ____/____/_____ M D Y b. Dose #2 ____/____/_____ M D Y
2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available). Date ____/____/_____ M D Y

C. SEROGROUP B MENINGOCOCCAL

The vaccine series must be completed with the same vaccine.

1. MenB-RC (Bexsero) __ routine ____outbreak –related
   a. Dose #1 ____/____/_____ M D Y b. Dose #2 ____/____/_____ M D Y

   OR

2. MenB-FHbp (Trumenba) __routine ___outbreak-related
   a. Dose #1 ____/____/_____ M D Y b. Dose #2 ____/____/_____ M D Y c. Dose #3 ____/____/_____ M D Y

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes ____ No ____ Date of last dose in series: ____/____/_____ M D Y
2. Date of most recent booster dose: ____/____/_____ M D Y Type of booster: Td _____ Tdap _____

E. INFLUENZA

Quadrivalent (IIV4) _____ Recombinant (RIV4) _____ Live attenuated influenza vaccine (LAIV) _____

Date of last dose: ____/____/_____ M D Y

F. COVID-19 *To Document COVID-19 vaccination, attach a copy of the patient's vaccine card to this form*

Product Name/Manufacturer: _____

a. Dose #1 ____/____/_____ M D Y b. Dose #2 ____/____/_____ M D Y c. Booster (Date of last dose) ____/____/_____ M D Y

G. HEPATITIS A

1. Immunization (hepatitis A)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

H. HEPATITIS B

Heplisav-B (2 dose series) is not interchangeable with other hepatitis B vaccines (3 dose series) but can substituted for dose #2 and #3.

1. Immunization (hepatitis B)

   a. Dose #1 ____/____/_____ (M D Y)
   Adult formulation ___ Child formulation ____
   HepB-CpG (Heplisav-B) ____

   b. Dose #2 ____/____/_____ (M D Y)
   Adult formulation ____ Child formulation ____
   HepB-CpG (Heplisav-B) ____

   c. Dose #3 ____/____/_____ (M D Y)
   Adult formulation ____ Child formulation ____
   HepB-CpG (Heplisav-B) ____

2. Immunization (Combined hepatitis A and B vaccine)

   a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

3. Quantitative Hepatitis B surface antibody (recommended for individuals born in or whose mother was born in a hepatitis B endemic country, and/or men who have sex with men; (required for health science students).

   Date ____/____/_____ (M D Y) Result: Reactive _____ Non-reactive_____

I. HUMAN PAPILLOMAVIRUS VACCINE

Immunization (indicate which preparation, if known) 9-valent (HPV9) _____ or other _____

a. Dose #1 ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y) c. Dose #3 ____/____/_____ (M D Y)

J. VARICELLA

1. Immunization

   a. Dose: ____/____/_____ (M D Y) b. Dose #2 ____/____/_____ (M D Y)

2. History of Disease Yes ___ No ___ or Birth in U.S. before 1980 Yes ___ No ___

K. PNEUMOCOCCAL VACCINES

PCV 13 _____ Date ____/____/_____ (M D Y) PPSV 23 _____ Date ____/____/_____ (M D Y)

L. POLIO

1. OPV alone (oral Sabin three doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y)

2. IPV/OPV sequential: IPV #1 ____/____/_____ (M D Y) IPV #2 ____/____/_____ (M D Y) OPV #3 ____/____/_____ (M D Y) OPV #4 ____/____/_____ (M D Y)

3. IPV alone (injected Salk four doses): #1 ____/____/_____ (M D Y) #2 ____/____/_____ (M D Y) #3 ____/____/_____ (M D Y) #4 ____/____/_____ (M D Y)

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____)_____

Return Immunization Record to:

Walsh University
Counseling & Health Services
2020 East Maple Street
North Canton, OH 44720
Phone: 330.490.7348
Fax: 330.490.7018
counselingservices@walsh.edu

Mail, email, fax, or return Immunization Record to Counseling & Health Services (located next the bookstore) in the David Campus Center.