UNIVERSITY OF NEW HAMPSHIRE
IMMUNIZATION RECORD

The University of New Hampshire requires verification of immunizations and/or serological test for Measles, Mumps, and Rubella. Exact dates are required. This form is to be completed by a health care provider. ***Please return this form to the student when it is completed. Thank you.***

Student Name: _____ UNH ID# _____ Date of Birth _____

Vaccines	Dates Given	New Hampshire Requirements/Recommendations
MMR	#1 ____/____/____ #2 ____/____/____	This is **required** by the University; if documentation is not received by the deadline an academic hold may be implemented.
OR		
Measles	#1 ____/____/____ #2 ____/____/____ Titer date ____/____/____	2 doses of MMR (Measles, Mumps, Rubella) or proof of positive titers. Include a copy of titers (Lab work).
Mumps	#1 ____/____/____ #2 ____/____/____ Titer date ____/____/____	or 2 doses Measles, 2 doses Mumps, and 1 dose Rubella
Rubella	#1 ____/____/____ Titer date ____/____/____	MMR#1 must be given after 1st birthday
Tdap/Td	Tdap ____/____/____ Td ____/____/____	Tdap/Td booster within the last 10 years
Meningococcal	Date ____/____/____	Recommended for all 1st year students living in dorms
Varicella (Chicken Pox)	History of illness: date ____/____/____ OR Immunizations: #1 ____/____/____ #2 ____/____/____ OR Titer date ____/____/____	2 doses of Varicella vaccine, minimum of 4 weeks between doses OR Positive Titer
Hepatitis B	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ OR Titer date ____/____/____	3 doses OR Positive Surface Antibody Titer
DTP/DTaP Series	Series completion date ____/____/____	
Polio Series OPV/IPV	Series completion date ____/____/____	
HPV Series	#1 ____/____/____ #2 ____/____/____ #3 ____/____/____	
TST (Tuberculin Skin Test) Mantoux Method	Date administered ____/____/____ Date read: ____/____/____ Results: _____ mm Chest x-ray date: ____/____/____	**Required only if at high risk** – see Tuberculosis Risk Questions located online Health History Form Results must be recorded in the ***exact measurement*** of induration. Include copy of chest x-ray report. If positive please provide detailed treatment plan.
History of BCG	Date ____/____/____	
OTHER	Vaccine: _____ Date: ____/____/____ Vaccine: _____ Date: ____/____/____ Vaccine: _____ Date: ____/____/___	

The above named patient is requesting exemption from the immunizations requirements/recommendations. Please provide proper documentation supporting the exemption(s). ☐ Health ☐ Religious ☐ Other

Health care provider's _____ _____ _____
(Signature) **(Print name)** **(Date)**

Address: _____ **Telephone: (** _____**)**_____