UNIVERSITY of WISCONSIN-EAU CLAIRE

Student Health Service, Crest Wellness Center, P.O. Box 4004, Eau Claire, WI 54702
Phone: (715) 836-4311 Fax: (715) 836-5979

Student Immunization Record

Actual Dates of Immunization for your records or Physician's Documented Records Are Necessary
Please return completed form to the above address or fax number

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____/_____/_____ Student ID # _____

*Student may **NOT** have had all of the following immunizations. Complete the immunizations the student has had and leave the rest blank.*
***NO** immunizations are required for entrance into the university. However, it is **highly recommended** that the student be current on all vaccinations. The Meningococcal and Hepatitis B vaccination statement form is also required to be completed by students that will be living in residence halls and returned to the Housing Department.*

HEPATITIS A

Dose #1____/____/_____
Dose #2____/____/_____

HEPATITIS B

Dose #1____/____/_____
Dose #2____/____/_____
Dose #3____/____/_____

HPV (Human Papilloma Virus)

Dose #1____/____/_____
Dose #2____/____/_____
Dose #3____/____/_____

MENINGOCOCCAL (Meningitis)

Date____/____/_____

MMR (Measles, Mumps, Rubella)

Dose #1____/____/_____
Dose #2____/____/_____

POLIO

Dose #1____/____/_____ Dose #3____/____/_____
Dose #2_____/_____/_____ Dose #4____/____/_____

TETANUS-DIPTHERIA

Dose #1____/____/_____ Dose #4____/____/_____
Dose #2____/____/_____ Dose #5____/____/_____
Dose #3____/____/_____

Please circle if known
Booster #1____/____/_____ Td Tdap
Booster #2____/____/_____ Td Tdap

VARICELLA (Chicken Pox)

History of disease Date____/____/_____
Or

Reactive Varicella antibody blood test
Date____/____/_____
Or

Immunization Dose #1____/____/_____
Dose #2____/____/_____

I certify that the above information is an accurate statement of the dates on which immunizations were received.

Student'/legal guardian's signature: _____ Date: _____

Medical Exemption
The student named above does not have one or more of the immunizations because he/she has:
(check all that may apply and fill in the corresponding blanks)

- ❑ shown laboratory evidence of immunity against _____ disease(s)
- ❑ a medical problem that precludes the _____ vaccine(s)
- ❑ had disease_____
- ❑ not been immunized because of a history of _____ disease

Healthcare provider's signature: Date:

Conscientious Exemption
I hereby certify by my signature that immunization against _____ is contrary to my conscientiously held beliefs.

Student'/legal guardian's signature: Date: