UNIVERSITY OF HARTFORD

in partnership with Higher Education

IMMUNIZATION RECORD

GRADUATE

Please have your healthcare provider complete and sign this form. Bring this form with you along with a copy of your immunization records.

THIS FORM MUST BE ON FILE PRIOR TO START OF CLASSES OR MOVING ONTO CAMPUS.

*This is the only form we will accept.

Student Information

This section must be completed

Name

Date of Birth MM DD YYYY Male ☐ Female ☐ UHA ID#

Cellphone

Permanent Home Information

Home Address

Zip Code

Home Phone#

Measles Vaccine:
First dose must have been administered on or after the student's first birthday, AND must have been administered on or after 1/1/69. The **second dose** must have been administered on or after 1/1/80. (Exempt if born before 12/31/56)

Mumps Vaccine: Must have been administered on or after the student's first birthday.

Rubella (German Measles) Vaccine: Must have been administered on or after the student's first birthday.

Required Immunizations

This section must be completed by either a physician or someone operating under the direction of a physician, i.e., school nurse, PA, APRN. Record of Immunizations (month/day/year). If you have a copy of these records from another institution, you may attach them to this from.

Measles

Dose 1 MM DD YYYY Dose 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report. Date of Test MM DD YYYY ☐ Pos ☐ Neg

Mumps

Dose 1 MM DD YYYY Dose 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report. Date of Test MM DD YYYY ☐ Pos ☐ Neg

Rubella

Dose 1 MM DD YYYY Dose 2 MM DD YYYY

☐ **OR** positive blood titer with REQUIRED copy of lab report. Date of Test MM DD YYYY ☐ Pos ☐ Neg

Varicella

Varicella is required only for students born on or after January 1, 1980

Dose 1 MM DD YYYY Dose 2 MM DD YYYY Provider initials

☐ **OR** Incidence of disease Chicken Pox Date MM DD YYYY

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Meningitis Vaccine
Required for any students living in campus housing.
Vaccine must be within 5 years of entry to the University

Date of Vaccine MM DD YYYY

I will be living in campus housing ☐ Yes ☐ No

Other Vaccine History
Varicella is required only for students born on or after January 1, 1980

Hepatitis B #1 MM DD YYYY

Hepatitis B #2 MM DD YYYY

Hepatitis B #3 MM DD YYYY

Hepatitis B Titer MM DD YYYY ☐ Pos ☐ Neg

Last Tetanus ☐ Td ☐ Tdap Date MM DD YYYY

HPV: Date #1 MM DD YYYY

HPV: Date #2 MM DD YYYY

HPV: Date #3 MM DD YYYY

Other Vaccination

Date of last Physical MM DD YYYY

Health Care Provider

I confirm that the information above is accurate.
Must be signed and stamped by Healthcare Provider

Name

Signature Date MM DD YYYY

Address

Zip Code

Phone

Fax

Continued

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Personal Medical History
Please check all that apply

- ☐ Acne
- ☐ Alcohol/drug use
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Bleeding trait
- ☐ Bipolar
- ☐ Breast disease
- ☐ Cancer
- ☐ Residential Life Information
- ☐ Cerebral Palsy
- ☐ Chronic Bronchitis
- ☐ Depression
- ☐ Diabetes Type I / Type II
- ☐ Eating disorder
- ☐ Hay fever/Allergies
- ☐ Hepatitis
- ☐ Heart disease
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Insomnia/Sleep prob
- ☐ Kidney stones/disease
- ☐ Menstrual Problems
- ☐ Migraine/Headaches
- ☐ Phlebitis
- ☐ Rheumatic fever
- ☐ Seizure disorder
- ☐ Skin disorder
- ☐ Tobacco user
- ☐ Other

Allergies
Drug and other Severe Adverse Reactions

Are any life threatening? ☐ Yes ☐ No Do you carry an Epi Pen? ☐ Yes ☐ No

Prior Hospitalizations or Surgeries

Please list dates and reasons

Medications—Frequent or regular

Please list all prescriptions, natural and over the counter medications.

Current Medical History

Conditions that we should know about?

Insurance Information

Name of Carrier

Policy # Group #

Policy Holder Policy Holder's DOB MM DD YYYY

RX # Bin

All forms must be turned into the IPP staff during the Orientation program beginning August 30, 2018.
You will NOT be able to move into campus housing and/or start classes unless fully compliant.