IMMUNIZATION HISTORY

Carthage College requires all new students to submit their immunization history. You must have your healthcare professional complete and sign this form or provide a copy of your vaccination history. You can obtain your vaccination records from your healthcare professional or former high school. If you are unable to obtain your vaccination history, you may need to be revaccinated or have an immunity profile completed. If you have any questions, please contact the Health and Counseling Center at (262) 551-5710 or health@carthage.edu.

Please complete this form by July 15, 2019 for Fall semester or by January 3, 2020 for January Term or Spring semester. This form can be mailed to the Health and Counseling Center in the yellow envelope provided, faxed to the Health and Counseling Center at 262-551-5726, or emailed to health@carthage.edu.

Required Immunizations
1. Tetanus, Diphtheria, Pertussis (Td or Tdap): Must be within the last ten years of the first day of the semester.
   Td ___________________ OR Tdap ___________________

2. MMR (Measles, Mumps, Rubella): Two doses of MMR are required, at least 28 days apart. The first vaccination must be given after 12 months of age AND both given after 12/31/1967.
   #1_______ #2____________

Recommended Immunizations
1. Polio: #1_______ #2_______ #3_______ #4_______ #5_______
   (OPV or IPV)

2. Hepatitis B #1_______ #2_______ #3_______

3. Meningococcal (MCV4): One or two doses of MCV4 are recommended for all students, especially for college students living in residence halls. If the first dose was given before age 16, a booster is recommended. If the initial dose given is at age 16 or older, no booster dose is required.
   #1_______ #2____________

4. Varicella #1_______ #2_______ OR History of Disease (Month/Year) ______________
   (Chicken Pox)

5. Hepatitis A #1_______ #2_______

6. HPV #1_______ #2_______ #3_______

Additional Immunization
Serogroup B Meningococcal (MenB): MenB is currently recommended for those at increased risk for meningococcal disease attributable to serogroup B. Two or three doses of Trumenba® or two doses of Bexsero® are recommended for this series.
   #1_______ #2_______ #3_______

REQUIRED HEALTHCARE PROVIDER VERIFICATION

Provider Signature __________________________ Date __________________________

NOTE: This form will not be accepted unless your physician SIGNS and STAMPS the form. If your physician cannot stamp this form, provide a copy of your vaccination records.