LAST NAME FIRST NAME MIDDLE NAME

Carthage College Health and Counseling Center
2001 Alford Park Drive, Kenosha, WI 53140-1994

DATE OF BIRTH STUDENT ID NUMBER

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 as soon as possible and return to the Health & Counseling Center via email to health@carthage.edu. Records can also be mailed Attn: Health & Counseling Center 2001 Alford Park Drive Kenosha, WI 53140.

Month, day, and year must be provided for each vaccination.

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 studentsIf 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_____

7. COVID19 #1_____ #2_____ Booster:_____ Manufacturer:_____

Serogroup B Meningococcal (MenB): 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 provide a copy of your vaccination records.

Clinic Stamp Here: