MONTANA STATE UNIVERSITY

Student Health Service
MSU-Bozeman PO Box 173260
Bozeman, MT 59717-3260
Telephone: (406) 994-2311
Fax: (406) 994-2504
www.montana.edu/health

MSU Student Health Service Immunization Record

Part I ~ IDENTIFICATION ~ Please Print or Type

Name: _____ Student ID# _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) _____ Telephone #

Birthday_____/_____/_____ Sex: M / F _____ Email Address

Father's Name: _____ Mother's Name: _____

Person to Notify in case of Emergency

Emergency contact: _____ (Name) _____ Phone/Cell Phone

Part II ~ TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

Your high school, private physician, or city health department may be able to help you find proof of your vaccinations.

We will gladly accept a copy of your records as proof of vaccination, but please include your full name (as it appears on your MSU application), Date of Birth, and your MSU ID # when you send it to us. Religious or medical exemptions can be granted if appropriate.

All information must be in English.

REQUIRED IMMUNIZATIONS

The following immunizations are either required or recommended by state law or MSU policy. This information **must be from your physician's records, or other official immunization** records and signed by a medical professional. Deadline: One week before attending your scheduled Orientation Program.

A. MMR (MEASLES, MUMPS, RUBELLA)

(Two doses required at least 28 days apart for students born after January 1, 1957. Any given before 1968 are not considered adequate. Dose 2 must be given after 1980.)

1. Dose 1 given at age 12 months or later #1 _____/_____/_____ (M D Y)
2. Dose 2 given at least 28 days after first dose #2 _____/_____/_____ (M D Y)

B. TUBERCULOSIS Screening Form ~ see form. Testing may or may not be required.

The following immunizations are recommended, but not required for admission to MSU.

Please fill in ***all of the immunizations*** that student has received.

C. MENINGOCOCCAL QUADRIVALENT
(A, C, Y, W-135)

Quadrivalent conjugate

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y)

D. TETANUS, DIPHTHERIA, PERTUSSIS

1. Primary series completed? Yes_____ No_____
   Date of last dose in series: _____/_____/_____ (M D Y)
2. Date of most recent booster dose: _____/_____/_____ (M D Y)

   Type of booster: Td_____ Tdap_____

   Tdap booster recommended for ages 11-64 unless contraindicated.

(Continued)

The following immunizations are recommended, but not required for admission to MSU.

E. HEPATITIS A

1. Immunization (hepatitis A)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y)

2. Immunization (Combined hepatitis A and B vaccine)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y)

F. HEPATITIS B

Three doses of vaccine, or a positive hepatitis B surface antibody meets the requirement.

1. Immunization (hepatits B)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

Adult formulation _____ Child formulation _____ Adult formulation _____Child formulation _____ Adult formulation _____Child formulation _____

2. Immunization (Combined hepatits A and B vaccine)

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

Adult formulation _____ Child formulation _____ Adult formulation _____Child formulation _____ Adult formulation _____Child formulation _____

3. Hepatits B surface antibody Date_____/_____/_____ (M D Y) Result: Reactive _____ Non-reactive _____ Attach a copy of lab report

G. HUMAN PAPILLOMAVIRUS VACCINE (HPV2 OR HPV4)

(Three doses of vaccine for female or male college students 11-26 years of age at 0, 1/2, and 6 month intervals.)

Immunization (indicate which preparation) Quadrivalent (HPV4) _____ or Bivalent (HPV2) _____

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)

H. VARICELLA (CHICKEN POX)

A history of chicken pox, a positive varicella anitbody, or two doses of vaccine meets the requirement.)

1. History of Disease Yes _____ No _____
2. Varicella antibody _____/_____/_____ (M D Y) Result: Reactive _____ Non-reactive _____ attach a copy of lab report
3. Immunization

Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y)

I. POLIO

(Primary seris, doses at least 28 days apart. Three primary series are acceptable. See ACIP website for details.)

1. OPV alone (oral Sabin three doses) Dose #1 _____/_____/_____ (M D Y) Dose #2 _____/_____/_____ (M D Y) Dose #3 _____/_____/_____ (M D Y)
2. IPV/OPV sequential: IPV #1 _____/_____/_____ (M D Y) IPV #2 _____/_____/_____ (M D Y) OPV#3 _____/_____/_____ (M D Y) OPV #4 _____/_____/_____ (M D Y)
3. IPV alone (injected Salk four doses)

Doses: #1 _____/_____/_____ (M D Y) #2 _____/_____/_____ (M D Y) #3 _____/_____/_____ (M D Y) #4_____/_____/_____ (M D Y)

J. INFLUENZA

Date of last dose: _____/_____/_____ (M D Y)

Trivalent inactivated influenza vaccine (TIV) _____ Live attenuated influenza vaccine (LAIV) _____

K. PNEUMONOCCAL POLYSACCHARIDE VACCINE (One dose for members of high-risk groups.)

Date _____/_____/_____ (M D Y)

Medical Professional's Name: _____ Date: _____

Medical Professional's Signature: _____ Phone: _____

Address: _____ (Street) _____ (City) _____ (State) _____ (Zip) Fax: _____