**WVU School of Medicine**

**Medical Laboratory Science**

**Personal Immunization Record**

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BIRTHDATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

GENDER: M F (circle one) ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

We require the following immunizations: MMR (2 doses); Hepatitis B (3 doses); Varicella (2 doses if non‐immune titer or no history of disease); Tetanus (1 dose within 10 years); Polio (initial series and booster at age 4‐6); PPD (The Two‐step Mantoux tuberculin skin test (TST) is required for initial skin testing.) Meningococcus (required by WVU)

**1. M.M.R. (Measles, Mumps, Rubella)**

MMR, Varicella, and Hepatitis B titers are required and must be included with this form on CastleBranch, if using this form to report your immunizations.

Vaccine #1 \_\_\_/\_\_\_/\_\_\_

Vaccine #2 \_\_\_/\_\_\_/\_\_\_

**2. Hepatitis B**

Vaccine #1 \_\_\_/\_\_\_/\_\_\_

Vaccine #2 \_\_\_/\_\_\_/\_\_\_

Vaccine #3 \_\_\_/\_\_\_/\_\_\_

**3. Varicella**

Vaccine #1 \_\_\_/\_\_\_/\_\_\_ or Self Reported Illness Date \_\_\_\_/\_\_\_/\_\_\_

Vaccine #2 \_\_\_/\_\_\_/\_\_\_

**4. Tetanus‐Diphtheria‐Pertussis (DTaP, Tdap, DT, Td)**

Vaccine: \_\_\_/\_\_\_/\_\_\_ (Td or TdaP?) circle one

**5. Polio**

Booster: \_\_\_/\_\_\_/\_\_\_

**6. PPD (The Two‐step Mantoux tuberculin skin test (TST) is required for initial skin testing.)**

Date applied \_\_\_/\_\_\_/\_\_\_ RESULTS: \_\_\_\_\_\_\_\_\_\_ Date Read \_\_\_/\_\_\_/\_\_\_

Date applied \_\_\_/\_\_\_/\_\_\_ RESULTS: \_\_\_\_\_\_\_\_\_\_ Date Read \_\_\_/\_\_\_/\_\_\_

**7. Meningococcus**

Vaccine \_\_\_/\_\_\_/\_\_\_

**Other Immunizations (if indicated)**

**Pneumovax** \_\_\_/\_\_\_/\_\_\_ **BCG** \_\_\_/\_\_\_/\_\_\_

**Health Care Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

(Signature)