**IMMUNIZATION RECORD**

**Graham Health Center at Oakland University**

SUBMIT TO GHC ON MOVE- IN DAY OR SEND A COPY OF THIS FORM VIA:

|  |  |  |
| --- | --- | --- |
| Mail:Graham Health Center 408 Meadow Brook RdRochester, MI 48309-4401 | Email: Health@oakland.edu | Fax:248-370-2691 |

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 *Last First Middle*

Today’s Date \_\_/ \_\_/ \_\_ DOB \_\_/ \_\_/ \_\_ G#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 M D Y M D Y

**MMR Vaccine** *(Measles, Mumps, Rubella)*

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_

 M D Y M D Y

**Varicella Vaccine** *(Chickenpox)*

History of Disease? Yes\_\_\_ No\_\_\_ or Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_

 M D Y M D Y

**Tetanus-Diphtheria-Pertussis Vaccine**

Last Booster: **Td** or **Tdap** *(please circle)* \_\_\_/ \_\_\_/ \_\_\_

 M D Y

**Human Papillomavirus Vaccine** *(Gardasil)*

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_ Dose #3 \_\_/ \_\_/ \_\_

 M D Y M D Y M D Y

**Hepatitis B Vaccine**

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_ Dose #3 \_\_/ \_\_/ \_\_

 M D Y M D Y M D Y

**Hepatitis A Vaccine**

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_

 M D Y M D Y

**Meningococcal Quadrivalent (A, C, Y, W-135)**

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_  *(needed if received first dose before age 16)*

 M D Y M D Y

**Meningococcal Serougroup B** *(Bexsero or Trumenba)*

Dose #1 \_\_/ \_\_/ \_\_ Dose #2 \_\_/ \_\_/ \_\_ Dose #3 \_\_/ \_\_/ \_\_ *(Trumenba*)

 M D Y M D Y M D Y

**TUBERCULOSIS SCREENING**

If you were born outside of the United States, complete and submit the attached TB screening form.

**Tuberculosis (TB) Screening Questionnaire**

Please answer the following questions:

1. Were you born in one of the countries listed below? \_\_Yes \_\_No (if yes, stop here)

**A** Albania, Andorra, Antigua and Barbuda, Australia, Austria
**B** Bahamas, Barbados, Belgium, British Virgin Islands
**C** Canada, Chile, Cook Islands, Costa Rica, Croatia, Cuba, Cyprus, Czech Republic
**D** Denmark, Dominica
**E** Egypt
**F** Finland, France, French Polynesia
**G** Germany, Greece, Grenada
**H** Hungary
**I** Iceland, Ireland, Israel, Italy
**J** Jamaica, Japan, Jordan
**L** Lebanon, Luxembourg
**M** Macedonia (Yugoslav Republic of), Malta, Monaco, Montenegro
**N** Netherlands, New Zealand, Norway
**O** Oman
**S** Saint Kitts and Nevis, Saint Lucia, Samoa, San Marino, Saudi Arabia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Syrian Arab Republic
**T** Tonga
**U** United Arab Emirates, United Kingdom, United States (includes Puerto Rico)

If you were **not** born in one of the countries listed above, please indicate your country of birth:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you were **not**born in one of the countries listed; have lived in or traveled to a country with a high rate of TB; or have had close contact with anyone who has had active TB it is recommended you have a Mantoux skin test or QuantiFERON TB Gold. These are available at Graham Health Center or your local health department.

**If your TB test is negative or non-reactive** when read by your medical provider:

* Send us your results.

**If your TB test is positive or reactive** when read by your medical provider, you must:

* Obtain a chest x-ray from your medical provider and submit your test results.
* If the chest X-ray is normal and you have no symptoms of active TB, you have inactive, latent TB.
* If you have an abnormal chest X-ray or symptoms of active TB, you may be required to have additional tests.
* Send us your results.