Program: 2021 High School Summer Program
From: Health Services
Re: Health Records: Immunization Record

Part One (to be completed by the student)

Last name | First name | Middle | (Chosen Name)

Home Address (# Street/Apt) | City | State | Zip

Today's Date | Student Date of Birth | Age

Part Two (to be completed by student's health care provider)

Do not attach an immunization record - In order to be an enrolled student at Landmark College you MUST provide proof of immunization. This immunization protocol is mandated by the State of Vermont.

A. **M.M.R. (Measles, Mumps, Rubella)** - Two doses required at least 28 days apart for students born after 1956.

Dose #1 date (mm/dd/yyyy) | Dose #2 date (mm/dd/yyyy) | -OR- | ☐ Reactive ☐ Non-Reactive Positive titer required

B. **VARICELLA** - Birth in the U.S. before 1980, a history of chicken pox, a positive varicella antibody, or two doses of vaccine meets the requirement. Both doses should be done prior to registration, as this is a state funded vaccine.

1. **History of Disease:** ☐ YES ☐ No (if no, proceed to 2)
2. **Immunization:** Dose #1 date (mm/dd/yyyy): Dose #2 date (mm/dd/yyyy):
3. **Varicella antibody:** date (mm/dd/yyyy): ☐ Reactive ☐ Non-Reactive

C. **TETANUS-DIPTHERIA-PERTUSSIS** - Booster with Td or Tdap in the last ten years.

Date of most recent booster (mm/dd/yyyy) | ☐ Td ☐ Tdap Type of booster (Tdap rec. for ages 11-64 unless contraindicated)

D. **HEPATITIS B** - Three doses of vaccine **or** a positive hepatitis B surface antibody meets the requirement.

Dose #1 date (mm/dd/yyyy) | Dose #2 date (mm/dd/yyyy) | Dose #3 date (mm/dd/yyyy)

☐ Reactive ☐ Non-Reactive
Positive titer required

E. **MENINGOCOCCAL TETRAVALENT -** A, C, Y, W-135 / for all students. College students over 25 years of age may choose to be vaccinated to reduce their risk of meningococcal disease.)

Dose #1 date (mm/dd/yyyy) | Dose #2 date (mm/dd/yyyy) – Revacinate if 1st dose was before age 16

Health Care Provider Name | MD/NP/PAA | date (mm/dd/yyyy)

Signature | Phone

Please return completed form via email to: HealthServices@landmark.edu