



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-	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive Positive titer required
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- 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-DIPHTHERIA-PERTUSSIS** - Booster with Td or Tdap in the last ten years.

Date of most recent booster (mm/dd/yyyy)	<input type="checkbox"/> Td <input type="checkbox"/> Tdap Type of booster (Tdap rec. for ages 11-64 unless contraindicated)
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- 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)
<input type="checkbox"/> Reactive <input type="checkbox"/> 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) – Revaccinate if 1 st dose was before age 16
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Health Care Provider Name	MD/NP/PAA	date (mm/dd/yyyy)
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Signature

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

Phone