Stanford | Vaden Health Center

Immunization Form for Stanford Non-Medical Students

Upload through the Vaden Patient Portal (vadenpatient.stanford.edu).

LAST NAME	FIRST NAME	MIDDLE INITIAL
DATE OF BIRTH (MM/DD/YYYY)	STANFORD UNIVERSITY IDENTIFICATION NUMBER (IF KNOWN)	

DO NOT SEND IMMUNIZATION RECORDS: *USE THIS FORM ONLY.*

REQUIRED

MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW	DATE #1 (GIVEN ON OR AFTER 12 MONTHS OF AGE)		DATE #2 (GIVEN 28 DAYS OR MORE AFTER #1 DOSE)
—OR—			
Measles (Rubeola) 2 DOSES REQUIRED FOR ALL STUDENTS BORN AFTER 1956	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***
Mumps 2 DOSES REQUIRED FOR ALL STUDENTS REGARDLESS OF AGE	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***
Rubella (German Measles) 1 DOSE REQUIRED FOR ALL STUDENTS REGARDLESS OF AGE	DATE #1		*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***

RECOMMENDED

Hepatitis B 3 DOSES REQUIRED	DATE #1	DATE #2	DATE #3	*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***
IF HISTORY OF HEPATITIS B DISEASE, A REPORT FOR HEP CORE ANTIBODY, HEP SURFACE ANTIBODY, AND HEP SURFACE ANTIGEN TITERS MUST BE INCLUDED.				
Tetanus-Diphtheria-Pertussis (Tdap) ONE-TIME DOSE AFTER AGE 10	TDAP DATE	**Tetanus-Diphtheria (Td)** (IF INDICATED)		LAST TD BOOSTER DATE
Varicella (Chicken Pox) 2 DOSES REQUIRED	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***	
Hepatitis A	DATE #1		DATE #2	
THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.				
Meningitis ACWY (LIST TYPE)	DATE #1		DATE #2	
Meningitis B (LIST TYPE)	DATE #1	DATE #2	DATE #3 (IF TRUMEMBA)	
HPV (LIST TYPE)	DATE #1	DATE #2	DATE #3	
Pneumococcal	DATE AND TYPE OF VACCINE #1		DATE AND TYPE OF VACCINE #2	

ADDITIONAL VACCINES

Japanese Encephalitis	DATE #1	DATE #2	DATE #3		
Rabies	DATE #1	DATE #2	DATE #3	DATE #4	
Typhoid	❑ INJECTABLE	❑ ORAL	DATE		
Yellow Fever	DATE				
Primary Polio Series	DATE #1	DATE #2	DATE #3	DATE #4	
Adult Polio Booster	DATE				
Primary Tetanus (DTaP) Series DATE #1	DATE #2	DATE #3	DATE #4	DATE #5	
Other (LIST HERE)	DATE(S)				

SIGNATURE OF HEALTH PROVIDER ***SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE*** DATE

PHYSICIAN/MEDICAL PROVIDER NAME (PLEASE PRINT OR USE CLINIC STAMP) ADDRESS

TELEPHONE NUMBER FAX NUMBER