# Immunization Form for Stanford Medical and Physician Assistant Students

See instructions on pages 12–16 for entering collected information and uploading this form via the VadenPatient secure web portal at vadenpatient.stanford.edu.

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

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**IF YOU ARE SENDING DIGITAL IMMUNIZATION RECORDS FROM YOUR ELECTRONIC HEALTH RECORD, YOU DO NOT NEED TO USE THIS FORM.**

### SARS Cov2 (Covid 19)
- **Primary Series Type**
- **Primary Series Date #1**
- **Primary Series Date #2**
- **Booster Type**
- **Booster Date #1**
- **Booster Date #2**

### 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)**

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**— OR —**

### Measles (Rubeola)
- 2 doses required for all students born after 1956:
  - **Date #1**
  - **Date #2**

### Mumps
- 2 doses required for all students regardless of age:
  - **Date #1**
  - **Date #2**

### Rubella (German Measles)
- 1 dose required for all students regardless of age:
  - **Date #1**

### Hepatitis B
- 3 doses required:
  - **Date #1**
  - **Date #2**
  - **Date #3**

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**— OR —**

### Varicella (Chicken Pox)
- 2 doses required:
  - **Date #1**
  - **Date #2**

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**THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.**

### Hepatitis A
- **Date #1**
- **Date #2**

### 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**

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### 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)**

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**SIGNATURE OF MEDICAL PROVIDER**

***SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE***

**DATE**

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

**ADDRESS**

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**TELEPHONE NUMBER**

**FAX NUMBER**

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**5.2023**