Stanford | Vaden Health Services

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)

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

REQUIRED

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)					
—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)***					
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) TDAP VACCINE MUST HAVE OCCURRED IN THE LAST 10 YEARS	DATE OF MOST RECENT TDAP						
Varicella (Chicken Pox) 2 DOSES REQUIRED	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY ***INCLUDE REPORT*** ***(REVACCINATE FOR EQUIVOCAL TITER)***				

RECOMMENDED

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 MEDICAL 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