# 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.

## Required Immunizations

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Doses Required</th>
<th>Dates Required</th>
<th>Additional Requirements</th>
</tr>
</thead>
<tbody>
<tr>
<td>MMR</td>
<td>2</td>
<td>Date #1 (12 mos. or after age)</td>
<td>Date #2 (28 days or more after #1 dose)</td>
</tr>
<tr>
<td>Measles (Rubeola)</td>
<td>2</td>
<td>Date #1</td>
<td>Date #2</td>
</tr>
<tr>
<td>Mumps</td>
<td>2</td>
<td>Date #1</td>
<td>Date #2</td>
</tr>
<tr>
<td>Rubella (German Measles)</td>
<td>1</td>
<td>Date #1</td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>3</td>
<td>Date #1</td>
<td>Date #2</td>
</tr>
<tr>
<td>Tetanus-Diphtheria-Pertussis (Tdap)</td>
<td>1</td>
<td>Date of most recent tetanus-diphtheria-pertussis (TDaP) vaccine must have occurred in the last 10 years</td>
<td></td>
</tr>
<tr>
<td>Varicella (Chicken Pox)</td>
<td>2</td>
<td>Date #1</td>
<td>Date #2</td>
</tr>
</tbody>
</table>

## Recommended Immunizations

- SARS Cov2 (Covid 19)
- Hepatitis A
- Meningitis ACWY
- Meningitis B
- HPV
- Pneumococcal
- Japanese Encephalitis
- Rabies
- Typhoid
- Yellow Fever
- Primary Polio Series
- Adult Polio Booster
- Primary Tetanus (DTaP) Series
- Other

## Vaccines Listed Below Are Recommended Based on Age or Disease Criteria. Please Check with Your Clinician.

- Japanese Encephalitis
- Rabies
- Typhoid
- Yellow Fever
- Primary Polio Series
- Adult Polio Booster
- Primary Tetanus (DTaP) Series

**IF HISTORY OF HEPATITIS B DISEASE, A REPORT FOR HEP CORE ANTIBODY, HEP SURFACE ANTIBODY, AND HEP SURFACE ANTIGEN TITERS MUST BE INCLUDED.**

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

### Additional Vaccines

- Japanese Encephalitis
- Rabies
- Typhoid
- Yellow Fever
- Primary Polio Series
- Adult Polio Booster
- Primary Tetanus (DTaP) Series

**SIGNATURE OF MEDICAL PROVIDER***

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

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

**DATE**

**TELEPHONE NUMBER**

**FAX NUMBER**

**6.2024**