



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	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	SARS Cov2 (Covid 19)	PRIMARY SERIES TYPE	PRIMARY SERIES DATE #1	PRIMARY SERIES DATE #2	BOOSTER TYPE	BOOSTER DATE #1	BOOSTER DATE #2	
	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	<input type="checkbox"/> INJECTABLE		<input type="checkbox"/> 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