SUBMIT OR E-MAIL BUTTON



**THIRD PARTY IMMUNIZATION FORM**

# Student Health Services

NAME STICKER

Date Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand this is the only third-party immunization form completed by Student Health Services. The charge for this form is non-refundable. I have checked with the institution requesting this form that it will be acceptable and give informed consent to release this information:**

Name Printed: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Signature: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Date Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**T. B. SCREENING**

OPTION 1:

Provide documentation of previous 2-step T.B. skin test (TST) ❑ Attached ❑ To Follow

Step One Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d) mm. induration: \_\_\_\_\_ Read Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d)

Step Two Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d) mm. induration: \_\_\_\_\_ Read Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d)

*(Step Two must take place a minimum 7 days after Step One)*

OPTION 2:

Single step TST

Step One Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d) mm. induration: \_\_\_\_\_ Read Date: \_\_\_\_\_\_\_\_\_\_ (yr/m/d)

CHEST X-RAY Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d) Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEASLE / MUMPS / RUBELLA**

Students must provide evidence of two doses of MMR or Serological evidence of immunity.

MEASLES Immunization Dates #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d)

Serology Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) Titres Rslt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MUMPS Immunization Dates #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d)

Serology Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) Titres Rslt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RUBELLA Immunization Dates #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d)

Serology Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) Titres Rslt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MMR given \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d) Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Third Party Immunization Form cont’d

**VARICELLA**

History? ❑ Yes ❑ No

Serology Date: \_\_\_\_\_\_\_\_\_\_\_\_\_(yr/m/d) Antibodies Detected: ❑ Yes ❑ No VARIVAX – Immunization Dates #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEPATITIS B**

Initial Vaccination Series #1 Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

#2 Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

#3 Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

Serology Anti-HBs antibody (HBsAb) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

❑ Reactive / Immune (+) Titre: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

❑ Non-Reactive / Not Immune (-)

Serology Hepatitis B Surface Antigen (HBsAg) Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

❑ Positive (detected)

❑ Negative (not detected)

**HepB** Booster Dose Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

**HCV SEROLOGY** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d) ❑ Attached

(Hepatitis C) ❑ Detected

❑ Not Detected

**HIV SEROLOGY** Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d) ❑ Attached

❑ Detected

❑ Not Detected

**TETANUS / DIPHTHERIA / PERTUSSIS / POLIO**

Proof of primary series: ❑ Attached

**T / D /Acellular Pertussis / & or Polio**

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Vaccine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
 ***Administered at Student Health Services, University of Windsor***

**TETANUS / DIPHTHERIA / ACELLULAR PERTUSSIS**

Date of last dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

**INFLUENZA**

Proof of vaccination: ❑ Attached ❑ To Follow

Vaccine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Vaccination: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

Date of last booster \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaccine\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***per patient's documentation***

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SHS Third party Immunization Form cont’d

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Revision Date: May 2018

SHS Third Party Immunization Form cont’d

**INFLUENZA**

Proof of vaccination: ❑ Attached

Date of Vaccination:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Vaccine:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (yr/m/d)

**ADDITIONAL**

Vaccine History (i.e. Meningitis, BCG, etc.):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Physician's Signature**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Stamp:**