Morehouse School of Medicine Immunization Form

All incoming students must meet certain immunization requirements prior to matriculation. Please have this form completed by your primary care healthcare provider. *Do not send original vaccination records in place of completing this form.* Original records may be attached to this form as supplemental documentation. If for any reason you will not be able to comply with the requirements, please attach a letter of explanation signed by both you and your healthcare provider. For any questions or concerns contact the Student Health and Wellness Center at (404) 756-1241.

Upload this completed form to your Point and Click Patient Portal.

PART I (Completed by the student)

Name (First, Middle and Last): _____

Date of Birth: _____

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Date of Entry (MM/YYYY): _____/_____ MSM ID#: _____

Phone Number: (_____)_____

Email address (MSM email only): _____

Program (circle one): MPH MSBR MSNS MSCR PhD

PART II REQUIRED VACCINATIONS (Completed by your healthcare provider)

A. COVID-19

1. Dose # 1: ____/____/_____ Vaccine Type: _____
2. Dose # 2: ____/____/_____ Vaccine Type: _____
3. Booster: ____/____/_____ Vaccine Type: _____

B. HEPATITIS B (Complete option 1 or 2)

1. Hepatitis B only

Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

2. Combined hepatitis A and B vaccine

Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

C. INFLUENZA

1. Date of last dose: ____/____/_____

D. MENINGOCOCCAL QUADRIVALENT ACWY (At least 1 dose administered >16 years old)

1. Quadrivalent conjugate

Dose #1 ____/____/_____ Dose #2 ____/____/_____

E. MMR (MEASLES, MUMPS, RUBELLA)

1. Dose #1 given at age 12 months or later: ____/____/_____

2. Dose #2 given at least 28 days after first dose: ____/____/_____

OR

Measles titer ____/____/_____ Result: Immune _____ Non-Immune_____

Mumps titer ____/____/_____ Result: Immune _____ Non-Immune_____

Rubella titer ____/____/_____ Result: Immune _____ Non-Immune_____

F. TETANUS, DIPHTHERIA, PERTUSSIS (must be within the last 10 years)

1. Primary series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____

2. Date of most recent booster dose: ____/____/_____ Type of booster: Td _____ Tdap _____

G. VARICELLA

1. Dose #1 given at age 12 months or later: ____/____/_____

2. Dose #2: ____/____/_____

OR

Varicella titer: ____/____/_____ Result: Immune _____ Non-Immune_____

Part III RECOMMENDED VACCINATIONS (Completed by your healthcare provider)

H. HEPATITIS A (Complete option 1 or 2)

1. Hepatitis A only

Dose #1 ____/____/_____ Dose #2 ____/____/_____

2. Combined hepatitis A and B vaccine

Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

I. HUMAN PAPILLOMAVIRUS VACCINE

Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

J. PNEUMOCOCCAL VACCINES

PCV 13 _____ Date ____/____/_____ PPSV 23 _____ Date ____/____/_____

K. POLIO

1. Series completed? Yes ___ No ___ Date of last dose in series: ____/____/_____

L. SEROGROUP B MENINGOCOCCAL (Complete option 1 or 2)

1. MenB-RC (Bexsero)

Dose #1 ____/____/_____ Dose #2 ____/____/_____

2. MenB-FHbp (Trumenba)

Dose #1 ____/____/_____ Dose #2 ____/____/_____ Dose #3 ____/____/_____

M. Other Vaccines Not Listed (BCG, Yellow Fever, Typhoid, Japanese Encephalitis, Rabies etc. and date(s) received): _____

HEALTH CARE PROVIDER

Name (please print): _____

Signature: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: (_____)_____ Fax: (_____)_____

Office Stamp: