



HARCUM

HARCUM COLLEGE

IMMUNIZATION FORM

Student Name (Print): _____

Date of Birth: _____

(BELOW SECTION TO BE COMPLETED BY MEDICAL PROVIDER)
COPY OF IMMUNIZATION RECORD REQUIRED

1. MMR (Measles, Mumps, Rubella) Dose: #1 ___/___/___
#2 ___/___/___

Or
MEASLES VACCINATION DATE: _____
MUMPS VACCINATION DATE: _____
RUBELLA VACCINATION DATE: _____

2. TETANUS/DIPHTHERIA BOOSTER DATE: ___/___/___
REQUIRED WITHIN THE PAST 10 YEARS

3. HEPATITIS B VACCINE SERIES: #1 ___/___/___
#2 ___/___/___
#3 ___/___/___

4. VARICELLA VACCINATION or #1 ___/___/___
HISTORY OF DISEASE: YES (circle) #2 ___/___/___

5. POLIO: OPV___ IPV___
Completed primary series Yes___ No___
Date of last Booster: ___/___/___

6. INFLUENZA Vaccine (*nursing students*) -----/-----/-----

7. TUBERCULOSIS: PPD (Mantoux) ___mm indurations negative ___
If positive, Chest x-ray required, attach report please positive ___
(*Nursing student's need two-step PPD*)
See titer form) Date placed _____ Date read _____

MEDICAL PROVIDER'S SIGNATURE _____ DATE _____

ADDRESS AND PHONE _____

