UNC
ESHELMAN
SCHOOL OF PHARMACY

IMMUNIZATION RECORD

Last Name | First Name | Middle/Maiden Name | Date of Birth (MM/DD/YYYY) | Personal ID# (PID)

SECTION A REQUIRED IMMUNIZATIONS

Please note that once the bottom of this form has been authenticated by a health care provider, no further revisions or additions can be made to the form without the notation (initials) of that health care provider.

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP / DTP / DT (Diphtheria, Tetanus, and Pertussis or Diphtheria-Tetanus; **minimum of three (3)** DTaP, DTP, DT, Td or Tdap vaccines. **One of those MUST be a Tdap** within the past 10 years and students must be current on their tetanus.)				
Td booster (Tetanus-diphtheria)				
Tdap booster (Tetanus-diphtheria and pertussis)				
Polio **An individual attending school who has attained their 18th birthday is not required to receive a polio vaccine.**				
MMR (Measles, Mumps, Rubella – two (2) MMR vaccines required on or after first birthday OR vaccines for the individual diseases in the form of two (2) Measles, two (2) Mumps and one (1) Rubella OR positive titer lab reports for all three diseases)				
Measles (two (2) required on or after first birthday OR positive titer lab report)				If titer, lab report must be submitted separately
Mumps (two (2) required on or after first birthday OR positive titer lab report)				If titer, lab report must be submitted separately
Rubella (one (1) required on or after first birthday OR positive titer lab report)				If titer, lab report must be submitted separately
Hepatitis B Series (a minimum of three (3) vaccines is required in addition to a positive titer lab report)				Required titer lab report must be submitted separately
Varicella (chicken pox – two (2) vaccines OR positive titer lab report)				If titer, lab report must be submitted separately

SECTION B REQUIRED HEALTH SCREENINGS

TB Blood Test***	***Required lab report must be submitted separately. QuantiFERON Gold or T-Spot accepted. If other IGRA test, please contact ESOP_Compliance@unc.edu for directive.

Signature of Health Care Provider _____ **Date** _____

Printed Name of Health Care Provider _____ **Area Code/Phone Number** _____

Office Address _____ **City** _____ **State** _____ **Zip Code** _____