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,** followed by a Td booster every 10 years)				
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, indicate results and date when titer was received
Mumps (two (2) required on or after first birthday OR positive titer lab report)				If titer, indicate results and date when titer was received
Rubella (one (1) required on or after first birthday OR positive titer lab report)				If titer, indicate results and date when titer was received
Hepatitis B Series (3 Hepatitis B doses OR a 2 dose Heplisav-B series is acceptable. Heplisav-B is only available in the United States.) in addition to a positive quantitative titer lab report)				Required titer lab report must be submitted separately in RxPreceptor/CORE ELMS
Varicella (chicken pox – two (2) vaccines OR positive titer lab report)				If titer, indicate results and date when titer was received

Signature of Health Care Provider _____ Date _____

Printed Name of Health Care Provider _____ Phone Number _____

Office Address _____ City _____ State _____ Zip Code _____