



Immunization Record for Ohio Wesleyan University Health Center

Name: _____

Date of birth: ____/____/____

Items A-F are **REQUIRED** to be completed **prior to attending classes**.

Items G-J are **highly recommended** for everyone.

Items K-N are recommended for members of certain higher risk groups or those who plan to study abroad or travel overseas.

REQUIRED VACCINES:

A: TETANUS, DIPHTHERIA, PERTUSSIS (DTP, DTaP, DT, Td or Tdap) - Items 1 and 2 are REQUIRED:

1. Primary series of four doses of either DTaP, DT, DTP or Td #1 ____/____/____ #2 ____/____/____ #3 ____/____/____
M D Y M D Y M D Y
#4 ____/____/____
M D Y

2. Most recent booster (must be within 10 years): ____/____/____ Type of booster: Td ____ Tdap ____
M D Y

B: MEASLES, MUMPS, RUBELLA (MMR) – Two doses are required.

1. Dose #1 ____/____/____ 2. Dose #2 ____/____/____
M D Y M D Y
28 days after #1

If Measles, Mumps and Rubella vaccines were given separately, that is acceptable as long as 2 of each were completed; please list vaccines and dates.

C: POLIO

At least three doses are required. Please indicate if each dose was either OPV or IPV.

#1 ____/____/____ #2 ____/____/____ #3 ____/____/____ #4 ____/____/____
M D Y M D Y M D Y M D Y
OPV or IPV OPV or IPV OPV or IPV OPV or IPV

D: HEPATITIS B

Three doses of child vaccine, or two doses of adult vaccine in adolescents 11-15 years old, or a positive hepatitis B surface antibody meets the requirement.

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____
M D Y M D Y M D Y

Formulation: Child or Adult Child or Adult Child or Adult
(Please circle one) (Please circle one) (Please circle one)

OR Hepatitis B surface antibody Date ____/____/____ Result: Reactive ____ Non-reactive ____
M D Y

E: MENINGOCOCCAL QUADRIVALENT (A, C, Y, W-135)

At least one dose required, but students younger than 22 years need a MCV booster dose if their previous dose was given before age 16 years.

1. Dose #1 ____/____/____ 2. Dose #2 ____/____/____
M D Y M D Y

Type: _____ Type: _____

F: COVID 19 VACCINE

Pfizer Dose #1 ____/____/____ Dose #2 ____/____/____ or Moderna Dose #1 ____/____/____ Dose #2 ____/____/____
or Johnson and Johnson ____/____/____

PLUS

Booster Dose ____/____/____



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Recommended but not required vaccines:

G: VARICELLA

Two doses of vaccine is recommended unless a history of chicken pox, or born in the US before 1980.

1. History of Disease Yes ___ No ___

2. Immunization

a. Dose #1 ____/____/____
M D Y

b. Dose #2 ____/____/____
M D Y

H: HUMAN PAPILOMAVIRUS VACCINE (HPV2 or HPV4)

Three doses of vaccine recommended for females and males 11-26 years of age

Circle formula received: Gardasil Gardasil 9 or Cervarix

a. Dose #1 ____/____/____
M D Y

b. Dose #2 ____/____/____
M D Y

c. Dose #3 ____/____/____
M D Y

I: INFLUENZA – Recommended yearly

J: SEROGROUP B MENINGOCOCCAL

MenB-RC (Bexsero) ___ Routine ___ Outbreak Related

Dose #1 ____/____/____
M D Y

2. Dose #2 ____/____/____
M D Y

OR

MenB-FHbp (Trumenba) ___ Routine ___ Outbreak Related

a. Dose #1 ____/____/____
M D Y

b. Dose #2 ____/____/____
M D Y

c. Dose #3 ____/____/____
M D Y

K: PNEUMOCOCCAL POLYSACCHARIDE VACCINE

One dose recommended for students with certain medical conditions: asthma, current history of smoking, diabetes, immunosuppression

Date ____/____/____
M D Y

L: HEPATITIS A

Recommended for routine use in all adolescents through the age of 18, for students traveling to countries where hepatitis A is moderately or highly endemic, men who have sex with men, users of injectable and noninjectable drugs, etc.

1. Dose #1 ____/____/____ Dose #2 ____/____/____
M D Y M D Y

M: TYPHOID

For students who intend to study abroad or travel overseas

Date of last dose: ____/____/____
M D Y

N: YELLOW FEVER

For students who intend to study abroad or travel overseas

Date of last dose ____/____/____
M D Y



Immunization Record for Ohio Wesleyan University Health Center

Name: _____

Date of birth: ____/____/____

HEALTH CARE PROVIDER

Name _____ Signature _____

Address _____ Phone (_____) _____

_____ Fax (_____) _____

**Please return to: OWU Student Health Center ♦ Stuyvesant Hall ♦ Delaware, Ohio 43015
Phone (740) 368-3160 ♦ Fax (740) 368-3166 ♦ health@owu.edu**