



**University of Notre Dame Immunization Form**  
 Enter info and upload records/lab results at Online Student Health  
 (nd.medicatconnect.com)

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ Date of birth: \_\_/\_\_/\_\_ ND ID #: \_\_\_\_\_

**REQUIRED IMMUNIZATIONS** (dates must be in MM/DD/YY format)

<b>Hepatitis B</b> Or attach lab report showing immunity	Date #1	Date #2	Date #3 if applicable	Name of Vaccine
<b>Meningococcal, (ACYW) - after age 16;</b> All students under age 21 living on campus	Date	Name of Vaccine		
<b>MMR (Measles, Mumps, Rubella)</b> Or attach lab report showing immunity	Date #1	Date #2		
<b>Tetanus-Diphtheria-Pertussis (Tdap)</b>	Tdap (at or after age 10) Date		Td (if Tdap was received >10 years ago) Date	
<b>Varicella (Chicken Pox)</b> Or attach lab report showing immunity; or provider documentation of disease; or birth before 1980	Date #1	Date #2	<b>OR</b> Date of Disease ____/____ (MM/YY)	

\*\*\*Tuberculosis Screening is required for students from countries with high incidence, you will be contacted via email by University Health Services upon arrival to campus

**ADDITIONAL IMMUNIZATION HISTORY (helpful for future travel abroad)**

<b>Hepatitis A</b>	Date #1	Date #2		
<b>HPV</b>	Date #1	Date #2	Date #3	Name of Vaccine
<b>Japanese Encephalitis</b>	Date #1	Date #2		Booster Date
<b>Meningitis B</b> (doesn't satisfy ACYW requirement)	Date #1	Date #2	Date #3 if applicable	Name of Vaccine
<b>Pneumococcal</b>	Date		Name of Vaccine	
<b>Polio, adult booster</b>	Date			
<b>Rabies</b>	Date #1	Date #2		Date #3
<b>Typhoid</b>	Date		__ Injectable __ Oral	
<b>Yellow Fever</b>	Date			

Health Provider signature: \_\_\_\_\_

Date: \_\_\_\_\_

*Signing provider verifies accuracy of above info*

Health provider name (please print): \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**Clinic  
stamp**

**AUTHORIZATION FOR CARE IF STUDENT IS UNDER AGE 18:** I authorize, at the discretion of the UHS personnel, medical and surgical care including but not limited to: examinations, treatments, and immunizations for my child. In the event of serious disease or injury or need for major surgery, all reasonable efforts will be made to contact me, but failure to make contact will not prevent emergency treatment necessary to preserve life or health.

Parent/Guardian signature: \_\_\_\_\_

Date: \_\_\_\_\_