UNIVERSITY OF NOTRE DAME
University Health Services

University of Notre Dame Immunization Form

Enter dates and upload document at nd.studenthealthportal.com

Last name: _____ First name: _____ Date of birth: ___/___/___ ND ID #: _____

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

Make sure to complete this form and the other required forms found under "My Forms" on the portal above

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

***Tuberculosis Screening is required for international 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)

COVID-19 (most recent vaccine)	Date		
Hepatitis A	Date #1	Date #2	
HPV	Date #1 Name of Vaccine	Date #2 Name of Vaccine	Date #3 Name of Vaccine
Japanese Encephalitis	Date #1	Date #2	Booster Date
Meningitis B (doesn't satisfy ACYW requirement)	Date #1 Name of Vaccine	Date #2 Name of Vaccine	Date #3 if applicable Name of Vaccine
Pneumococcal	Date	Name of Vaccine	
Polio, adult booster	Date		
Rabies	Date #1	Date #2	Date #3
Typhoid	Date	_____ Injectable	_____ Oral
Yellow Fever	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: _____