Part 2

UWM Norris Health Center

P.O. Box 413
Milwaukee, WI 53201-0413
Phone: (414) 229-4716 Fax: (414) 229-6608

Self-Reported Immunization Record

NHC use only Date Received ___/___/___
MMR#1___#2___Td/Tdap___Varicella#1___#2__
HepB#1___#2___#3___Meningococcal____

Complete Y N Entered Y N
Reviewed by: _____

All newly admitted or readmitted students (after a two or more year absence from the University) are urged to return this completed form to Norris Health Center at the address above within 30 days of the start of the session/term of enrollment.

GENDER: M ☐ F ☐

LAST NAME (print) FIRST NAME MIDDLE

DATE OF BIRTH COUNTRY OF BIRTH PANTHER ID# UWM EMAIL

PERMANENT ADDRESS CITY STATE ZIP CODE AREA CODE/PHONE NUMBER

REGISTERING AS (circle): UNDERGRAD GRAD	SEMESTER/TERM ENTERING (circle): FALL SPRING SUMMER WINTERIM	______________ ENTRANCE YEAR

RECOMMENDED IMMUNIZATIONS

Please complete this form as soon as possible and then immediately make a copy for your records. You may obtain dates/documentation from your health care provider or previous school records. If documentation is unavailable, a laboratory report of a blood test (titer) to determine level of immunity or re-immunization is recommended. Immunizations and titers are available at the UWM Norris Health Center for a fee.
Call (414) 229-4716 for an appointment.

1. TETANUS/DIPHTHERIA OR Tdap

Booster dose within 10 years (Tdap preferred) Td or Tdap (circle) Booster: ____/____/____
(mon) (day) (year)

2. MMR (measles, mumps, rubella)

Immunization with two doses of MMR, given on or after first birthday and separated by at least one month

MMR #1____/____/____ (mon) (day) (year) MMR #2 ____/____/____ (mon) (day) (year)

OR

Measles #1____/____/____ (mon) (day) (year) Measles #2____/____/____ (mon) (day) (year) **or** attached lab report showing positive immunity____

Mumps #1____/____/____ (mon) (day) (year) Mumps #2 ___/____/____ (mon) (day) (year) **or** attached lab report showing positive immunity____

Rubella#1____/____/____ (mon) (day) (year) Rubella #2 ___/____/____ (mon) (day) (year) **or** attached lab report showing positive immunity____

3. VARICELLA

History of chickenpox disease, immunization or positive titer

Date of Chickenpox Disease____/____ (mon) (year) or attached lab report showing positive immunity____

OR

Varicella #1___/____/____ (mon) (day) (year) Varicella #2____/____/____ (mon) (day) (year)

4. **HEPATITIS B**

Series of 3 doses: 0, 1, 6 months

Hepatitis B #1: ___/___/___ (mon) (day) (year) Hepatitis B #2: ___/___/___ (mon) (day) (year) Hepatitis B #3: ___/___/___ (mon) (day) (year)

5. MENINGOCOCCAL (MCV4 or MPSV4)

Highly recommended for freshmen living in residence halls

Meningococcal: ___/___/___
(mon) (day) (year)

I HAVE READ AND UNDERSTAND THE IMMUNIZATION RECOMMENDATIONS OF THIS FORM AND THE ENCLOSED INFORMATION. This form has been truthfully completed to the best of my knowledge and I freely consent to this form being used for my treatment at University of Wisconsin-Milwaukee.

Student Signature:____Date:___________

Parent Signature (if under 18 years of age):________________________________Date:___________