

UNIVERSITY OF CHARLESTON
IMMUNIZATION FORM - Academic Year 20__ - 20__

PART I : (please print)

Name: _____
Last Name _____ First Name _____ Middle Name _____

Date of Birth: _____

PART II: (REQUIRED IMMUNIZATIONS)

A. M.M.R. (Mumps, Measles, Rubella) – two doses required

Dose #1: ____/____/____ (given at age 12-15 months)

Dose #2: ____/____/____ (at least one month after first dose)

B. Hepatitis B

Three doses of vaccine or two doses of adult vaccine in adolescent 11-15 years of age.

Dose #1: ____/____/____ Dose #2: ____/____/____

Dose #3: ____/____/____

C. Meningococcal vaccine

Date: _____ Type of vaccine used: (circle) Menomune or Menactra

Signature of Student

Date

Signature of Parent/Guardian (if under age of 18)

Date

Return completed form to: University of Charleston
Office of Student Life
2300 MacCorkle Avenue
Charleston, WV 25304
Telephone: 304-357-4745 Fax: 304-357-4915
E-mail: sle@ucwv.edu