



# Residential Living Immunization Record Form

This form must be submitted by all students who choose to live on campus.

**REQUIRED IMMUNIZATIONS for all residential students and is to be completed by a healthcare provider**

Student Name: \_\_\_\_\_  
Last First Middle

Gender : \_\_\_\_\_ Birthday: \_\_\_\_\_ Student ID : \_\_\_\_\_  
Month/Day/Year

**MMR (Measles, Mumps, Rubella):** Two doses are required for persons born after January 1, 1957

Dose 1 given at age 12 months or later

# 1 dose date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Dose 2 given at least 28 days after first dose

# 2 dose date: \_\_\_\_/\_\_\_\_/\_\_\_\_

**TETANUS-DIPHTHERIA:** Tdap booster recommended for ages 11-64 unless contraindicated, **must be within last 10 years:**

Date of most recent booster dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

Type of most recent booster: Td \_\_\_\_\_ Tdap \_\_\_\_\_

**VARICELLA (chicken pox):** Two doses of vaccine or history of disease

Date of 1st dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of 2nd dose: \_\_\_\_/\_\_\_\_/\_\_\_\_

or history of disease - Year: \_\_\_\_\_

**MENINGOCOCCAL (MCV4 is required):** Please Note, this must be **within last 5 years**

Date of Vaccine: \_\_\_\_/\_\_\_\_/\_\_\_\_

Date of Booster shot: \_\_\_\_/\_\_\_\_/\_\_\_\_

**TB SCREENING: (choose **one** method of testing)** Please note, test results must be **within last 3 months**

1. **Tuberculin Skin Test (TST):** (TST result should be recorded as actual millimeters (mm) or induration, transverse diameter; if no induration, writes "0".

Date Given: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date Read: \_\_\_\_/\_\_\_\_/\_\_\_\_ (must be within 48-72 hours)  
mm dd yyyy mm dd yyyy

Result: \_\_\_\_\_ mm Interpretation: POSITIVE \_\_\_\_\_ NEGATIVE \_\_\_\_\_ (based on mm of induration as well as risk factors)

2. **Interferon Gamma Release Assay (IGRA)** Date given \_\_\_\_/\_\_\_\_/\_\_\_\_ (specify method by circling one) QFT-G / QFT-GIT / T-Spot / \_\_\_\_\_ (OTHER)

3. **Chest x-ray: (Required if TST or IGRA is positive)** Date of chest x-ray: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: Normal \_\_\_\_\_ Abnormal \_\_\_\_\_

Signature of Healthcare Provider: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name and title of Health Care Provider: \_\_\_\_\_

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

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

Upon completion, this form needs to be scanned and emailed to [studentservices@piedmont.edu](mailto:studentservices@piedmont.edu)