Dickinson
WELLNESS CENTER

Immunization Record Form (To be Completed by Healthcare Provider)

- Healthcare provider must complete and sign this form or submit a signed copy of the immunization record.
- All information must be provided in English.
- Statements such as "received as child", "records not available", or "up to date" are not acceptable.

_____ _____

Last Name, First Name Date of Birth

REQUIRED IMMUNIZATIONS	1ST DOSE (M/D/Y)	2ND DOSE (M/D/Y)	Other
MMR Two (2) doses after 12 months of age given at least 28 days apart. OR a positive serologic test showing immunity with a copy of test attached.			OR Date of attached titer:
Tdap One (1) dose within the last 10 years. Td is not acceptable.			
Meningitis ACYW One (1) dose after age 16. OR sign a waiver (click for waiver) declining the vaccine.	Initial Dose:	Booster Dose:	OR Date of waiver:
Varicella Two (2) doses at least 12 weeks if vaccinated between ages 1-12 or at least 4 weeks apart if vaccinated at age 13 or older. OR positive serologic testing showing immunity with a copy of test attached.			OR Date of attached titer:
Meningitis B Two (2) doses 6 months apart, typically after age 16.			

RECOMMENDED VACCINES	1ST DOSE M/D/Y	2ND DOSE M/D/Y	3RD DOSE M/D/Y	4th DOSE M/D/Y
Covid-19 One (1) dose of an updated vaccine.	Last Dose:			
Hepatitis A Two (2) dose series.				
Hepatitis B 2, 3, or 4 dose series.				
HPV Two (2) dose series if given before age 15. Three (3) dose series if given at age 15 or older.				
Influenza One (1) dose annually.	Last Dose:			
Polio Four (4) dose series.				
Mpox Two (2) dose series for persons at risk				
Pneumococcal 0ne (1) or two (2) doses for persons ages 19-64 with risk factors				

_____ _____

Healthcare Provider Signature Date

_____

_____

Office Address, City, State, Zip (or Office Stamp) Phone