

**KUTZTOWN UNIVERSITY  
HEALTH ADMINISTRATIVE SERVICES  
PO BOX 730  
KUTZTOWN, PA 19530  
PHONE 610-683-4082, X2 FAX 610-683-4635**

**PLEASE PROVIDE IMMUNIZATION DOCUMENTATION FROM ONE OF THE FOLLOWING SOURCES:**

- High school records
- Medical Provider
- Previous college or university
- Military Records

**OR HAVE YOUR PHYSICIAN COMPLETE, SIGN AND DATE THIS DOCUMENT BELOW.**

**DOCUMENTATION RECEIVED IN THE ENCLOSED ENVELOPE WILL RECEIVE PRIORITY PROCESSING  
FAXED DOCUMENTATION MAY REQUIRE ADDITIONAL REVIEW (610-683-4635)**

**IMMUNIZATION REQUIREMENTS**

- **Tetanus (Td or Tdap)** – within the last 10 years
- **MMR 1** (measles, mumps, rubella) – given at age 12 months or later
- **MMR 2** (measles, mumps, rubella) – given at least 28 days after first dose

Student Name \_\_\_\_\_ DOB \_\_\_\_\_ KU ID# \_\_\_\_\_

**REQUIRED VACCINES**

Vaccine	Date Given
Td or Tdap (please circle one)	
MMR #1	
MMR #2	

OR Proof of positive MMR titer results. (Attach lab reports)

PRACTICE STAMP

**RECOMMENDED VACCINES (NOT REQUIRED)**

Vaccine	Date Given
Meningitis	
Varicella #1	
Varicella #2	

OR History of Chicken Pox (Provide Date or Age) \_\_\_\_\_

OR Proof of positive Varicella titer results. (Attach lab report)

Hep B #1	
Hep B #2	
Hep B #3	
HPV #1	
HPV #2	
HPV #3	

**PHYSICIAN'S SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

Name of Physician or Group \_\_\_\_\_

Address \_\_\_\_\_ Phone ( ) \_\_\_\_\_

**\*Clinician - Please initial any vaccine dates recorded on this form if they were given after the date of the doctor's signature**