TEMPLE UNIVERSITY®
Student Health Services

IMMUNIZATION FORM

Student Name: _____
Last Name First Name

TU ID#: _____ Date of Birth (mm/dd/yyyy): _____

Mailing Address: _____
Address

_____
City/ State/ Zip Code

(SECTION BELOW TO BE COMPLETED BY MEDICAL PROVIDER)

1. MMR (Measles, Mumps, Rubella) Dose: #1 _____/_____/_____
M D Y

#2 _____/_____/_____
M D Y

MEASLES VACCINATION DATE: _____
MUMPS VACCINATION DATE: _____
RUBELLA VACCINATION DATE: _____

2. TETANUS/DIPHTHERIA BOOSTER: _____/_____/_____
(WITHIN THE PAST 10 YEARS) M D Y
OR
TDAP _____/_____/_____
(PLEASE INDICATE WHICH) M D Y

3. HEPATITIS A VACCINE SERIES: #1: _____/_____/_____
M D Y

#2: _____/_____/_____
M D Y

4. HEPATITIS B VACCINE SERIES: #1: _____/_____/_____
M D Y

#2: _____/_____/_____
M D Y

#3: _____/_____/_____
M D Y

5. VARICELLA VACCINATION DATE: #1: _____/_____/_____
M D Y

#2: _____/_____/_____
M D Y

MEDICAL PROVIDER'S SIGNATURE_____ DATE _____

ADDRESS AND PHONE _____

SEND TO: TEMPLE UNIVERSITY: STUDENT HEALTH SERVICES
1700 N. BROAD STREET, 4TH FLOOR
PHILADELPHIA, PA 19121 (0662)