HOW TO COMPLETE THESE FORM(S):

- A licensed healthcare professional MUST complete and sign THESE forms. ALL green sections are required.
- PRINT CLEARLY WITH DARK BLACK INK. A computer will be reading your forms. Fill in circles completely.
- NO other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- Do not fold, cut, or mark on the border lines of these forms.
- Include the Border Lines in your scanned images.
- Review your forms for completeness and accuracy. Double check ALL signatures. MM/DD/YY date formats.
- Consult your Healthcare Professional before receiving any of the following immunizations.

Your records are due by: Orientation or 8/1/2018 ...whichever comes first!

REQUIRED

Required by regulation and/or policy to attend this university.

Documents:
Immunization Certificate

Immunization Dates:
Meningococcal (1 dose @ age 16 or older)
MMR (2 doses OR Pos. Titer)

RECOMMENDED

Recommended for your general well being but NOT required.

Immunization Dates:
Varicella
Polio
Hepatitis A
Hepatitis B
TDaP Booster
HPV
Meningococcal B

OPTIONAL

Optional information

Immunization Dates:

UPLOADING YOUR FORMS:

- Review your forms for completeness and accuracy. Double check ALL signatures.
- Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- Upload your completed forms to your account at medproctor.com.
- You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- Check your University Email account regularly for messages from MedProctor regarding incomplete information.
  
  You will be notified via email once your information is successfully verified.

BE AWARE:

* Incomplete/Illegible writing and poor images will be rejected.
* Completion of these forms by your due date will help expedite your registration process.

Do not upload this page.
# IMMUNIZATION CERTIFICATE

**University:** Xavier University  
**Student:** Test Client  
**DOB:** 1/1/1999

## Immunization Record

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>Status</th>
<th>Dates</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong> (Measles, Mumps, Rubella)** Required</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>MENINGOCOCCAL</strong> Required</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>MENINGOCOCCAL B</strong> Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>HEPATITIS B</strong> Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>HPV</strong> (Human Papillomavirus) Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>HEPATITIS A</strong> Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>VARICELLA</strong> - Chicken Pox Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>POLIO</strong> - Inactivated Recommended</td>
<td>1st</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>2nd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>3rd</td>
<td>MM DD YY</td>
</tr>
<tr>
<td></td>
<td>4th</td>
<td>MM DD YY</td>
</tr>
<tr>
<td><strong>TDaP / TD-Booster</strong> Recommended</td>
<td>Within 10 yrs.</td>
<td></td>
</tr>
</tbody>
</table>

**REQUIRED** - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)

- Licensed Care Professional Signature
- Print Licensed Health Care Professional First and Last Name
- Signature Date

**RECOMMENDED** - Two-Step Tuberculosis Test Results (7 to 365 days apart) OR Tuberculosis Blood Test Results

1. **1st Tb Skin Results**
   - PPD
   - Placed: MM DD YY
   - Read: MM DD YY
   - Actual induration in MM only: MM

2. **2nd Tb Skin Results**
   - PPD
   - Placed: MM DD YY
   - Read: MM DD YY
   - Actual induration in MM only: MM

**OR**

- T-Blood Test
  - T-Spot QuantiFERON
  - Results: Positive

**Tuberculosis Test Results Signature** (Please clearly complete ALL and place office stamp at bottom of page.)

- Licensed Care Professional Signature
- Print Licensed Health Care Professional First and Last Name
- Signature Date

**OFFICE STAMP**