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

**Documents:**
- Immunization Certificate

**Immunization Dates:**
- Men A/C/W/Y (1 dose @ age 16 or older)
- Hepatitis B (3 doses OR Pos. Quant. Titer)
- MMR (2 doses OR Pos. Titer)

### RECOMMENDED
Recommended for your general well being but NOT required.

**Immunization Dates:**
- Meningococcal B
- Two-Step Tb Results
- Varicella
- Polio
- Hepatitis A
- TDaP Booster
- HPV
- COVID-19

### OPTIONAL
Optional information

**Immunization Dates:**
- JE - Japanese Encephalitis
- Typhoid
- Yellow Fever
- Rabies

---

### 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.

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Do not upload this page.
# IMMUNIZATION CERTIFICATE

**PRINT CLEARLY WITH DARK BLACK INK.**

This form will be read by a computer.

Upload to medproctor.com

### University:
Xavier University

### Student:

<table>
<thead>
<tr>
<th>Vaccine</th>
<th>1st</th>
<th>2nd</th>
<th>3rd</th>
<th>4th</th>
<th>Required/Recommended/Optional</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MMR</strong></td>
<td>MM DD YY</td>
<td>MM DD YY</td>
<td>MM DD YY</td>
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<td><strong>POLIO</strong></td>
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<td><strong>TDaP</strong></td>
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<td><strong>TD</strong></td>
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<td><strong>Rabies</strong></td>
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<td><strong>Yellow Fever</strong></td>
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**COVID-19**

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<th>4th</th>
<th>Recommended/Optional</th>
</tr>
</thead>
<tbody>
<tr>
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<td></td>
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<tr>
<td><strong>POLIO</strong></td>
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<tr>
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**Meningococcal B**

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</tr>
</tbody>
</table>

**RECOMMENDED - Two-Step Tuberculosis Test Results (7 to 21 days apart) OR Tuberculosis Blood Test Results**

1st Tb Skin Results PPD

- Placed: MM DD YY
- Read: MM DD YY
- actual induration in MM only: mm

2nd Tb Skin Results PPD

- Placed: MM DD YY
- Read: MM DD YY
- actual induration in MM only: mm

OR

Tb Blood Test

- T-Spot QuantifiFERON
- Results +○○ - ○○

**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**

**NON-PARENTAL**

**NPI NUMBER**

**NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL**

**OFFICE PHONE NUMBER**

**OFFICE STAMP**

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