



**Must be completed and signed by a healthcare provider. Attach relevant documents, reports, and COVID-19 vaccination card. Submit by JULY 1, 2022.**



## Immunization Form for Curtis Institute of Music Students

LAST NAME	FIRST NAME	DATE OF BIRTH (MM/DD/YYYY)
EMAIL		CELL OR LOCAL NUMBER

<b>REQUIRED</b>	<b>Hepatitis B</b> 3 DOSES REQUIRED	DOSE #1	DOSE #2	DOSE #3	<i>OR</i> LABORATORY EVIDENCE OF IMMUNITY <b>ATTACH LAB REPORT</b> <i>(REVACCINATE FOR NEGATIVE TITER)</i>	
	<b>MMR</b> 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW. ADMINISTERED AFTER 1 <sup>ST</sup> BIRTHDAY	DOSE #1		DOSE #2		
	<b>—OR—</b>					
	<b>Measles (Rubeola)</b> 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1 <sup>ST</sup> BIRTHDAY	DOSE #1	DOSE #2		<i>OR</i> LABORATORY EVIDENCE OF IMMUNITY <b>ATTACH LAB REPORT</b> <i>(REVACCINATE FOR NEGATIVE TITER)</i>	
	<b>Mumps</b> 2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1 <sup>ST</sup> BIRTHDAY	DOSE #1	DOSE #2		<i>OR</i> LABORATORY EVIDENCE OF IMMUNITY <b>ATTACH LAB REPORT</b> <i>(REVACCINATE FOR NEGATIVE TITER)</i>	
	<b>Rubella (German Measles)</b> 1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1 <sup>ST</sup> BIRTHDAY	DOSE #1		<i>OR</i> LABORATORY EVIDENCE OF IMMUNITY <b>ATTACH LAB REPORT</b> <i>(REVACCINATE FOR NEGATIVE TITER)</i>		
	<b>Tetanus-Diphtheria-Pertussis (Tdap)</b> ONE-TIME DOSE AFTER AGE 10 (ADACEL OR BOOSTRIX)	TDAP DATE		<b>Tetanus-Diphtheria (Td)</b> (IF TDAP IS GREATER THAN 10 YEARS)		LAST TD BOOSTER DATE
	<b>Varicella (Chicken Pox)</b> 2 DOSES REQUIRED OR TITER	DOSE #1	DOSE #1	ILLNESS	<i>OR</i> LABORATORY EVIDENCE OF IMMUNITY <b>ATTACH LAB REPORT</b> <i>(REVACCINATE FOR NEGATIVE TITER)</i>	
	<b>Meningococcal ACYW-135</b> DOSE 1 GIVEN AGES 11-15 DOSE 2 GIVEN AGE 16 OR LATER	DOSE #1	DOSE #2		LIST VACCINE NAME OR SEROGROUPS COVERED: _____	
	<b>Tuberculosis Testing</b> INCOMING STUDENTS ARE REQUIRED TO HAVE TESTING FOR TUBERCULOSIS. SKIN TEST <b>OR</b> IGRA BLOOD TEST (Quantiferon TB Gold, T-Spot- TB) ACCEPTED IN LAST 6 MONTHS OF ENTRANCE. (SUBMIT LABORATORY EVIDENCE)	DATE PLACED		DATE READ	SIZE (IN mm)	

<b>RECOMMENDED</b>	THE VACCINES LISTED BELOW ARE RECOMMENDED BASED ON AGE OR DISEASE CRITERIA. PLEASE CHECK WITH YOUR CLINICIAN.					
	<b>Hepatitis A</b>	DOSE #1		DOSE #2		
	<b>HPV (Human Papilloma Virus)</b> <input type="checkbox"/> HPV4 <input type="checkbox"/> HPV9	DOSE #1	DOSE #2		DOSE #3	
	<b>Other</b> LIST VACCINE NAME: _____	DOSE #1	DOSE #2		DOSE #3	DOSE #4

<b>PROVIDER INFORMATION</b>	***SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE***		
	<b>Provider Name (Please Print)</b>	<b>Title</b>	
	<b>Address</b>	<b>Phone</b>	<b>Date</b>
	<b>Signature</b>	<b>Clinical or Organization Stamp</b>	

**Scan and email to Dean Tarditi, meredith.tarditi@curtis.edu, and bring paper originals with you to campus.**