Immunization Form for Curtis Institute of Music Students

**LAST NAME**  
**FIRST NAME**  
**DATE OF BIRTH (MM/DD/YYYY)**

**EMAIL**  
**CELL OR LOCAL NUMBER**

### Hepatitis B
3 DOSES REQUIRED

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
<th>DOSE #3</th>
</tr>
</thead>
</table>

**OR LABORATORY EVIDENCE OF IMMUNITY**  

**ATTACH LAB REPORT**  

**(REVACCINATE FOR NEGATIVE TITER)**

### MMR
2 DOSES REQUIRED OR INDIVIDUAL VACCINES
AS LISTED BELOW. ADMINISTERED AFTER 1ST BIRTHDAY

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
</tr>
</thead>
</table>

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**(REVACCINATE FOR NEGATIVE TITER)**

### Measles (Rubeola)
2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
</tr>
</thead>
</table>

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### Mumps
2 DOSES REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
</tr>
</thead>
</table>

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### Rubella (German Measles)
1 DOSE REQUIRED. MUST BE ADMINISTERED AFTER 1ST BIRTHDAY

<table>
<thead>
<tr>
<th>DOSE #1</th>
</tr>
</thead>
</table>

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### Tetanus-Diphtheria-Pertussis (Tdap)
ONE-TIME DOSE AFTER AGE 10 (ADACEL OR BOOSTRIX)

<table>
<thead>
<tr>
<th>TDAP DATE</th>
<th>Tetanus-Diphtheria (Td)</th>
<th>LAST TD BOOSTER DATE</th>
</tr>
</thead>
</table>

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### Varicella (Chicken Pox)
2 DOSES REQUIRED OR TITER

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #1</th>
<th>Illness</th>
</tr>
</thead>
</table>

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**(REVACCINATE FOR NEGATIVE TITER)**

### Meningococcal ACYW-135

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
<th>LIST VACCINE NAME OR SEROGROUPS COVERED:</th>
</tr>
</thead>
</table>

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**(REVACCINATE FOR NEGATIVE TITER)**

### Tuberculosis Testing
INCOMING STUDENTS ARE REQUIRED TO HAVE TESTING FOR TUBERCULOSIS. SKIN TEST OR IGRA BLOOD TEST (Quantiferon TB Gold, T-Spot- TB) ACCEPTED IN LAST 6 MONTHS OF ENTRANCE (SUBMIT LABORATORY EVIDENCE)

<table>
<thead>
<tr>
<th>DATE PLACED</th>
<th>DATE READ</th>
<th>SIZE (IN mm)</th>
</tr>
</thead>
</table>

### The Vaccines Listed Below Are Recommended Based on Age or Disease Criteria. Please Check With Your Clinician.

**Hepatitis A**

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
</tr>
</thead>
</table>

**HPV (Human Papilloma Virus)**

<table>
<thead>
<tr>
<th>HPV4</th>
<th>HPV9</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
<th>DOSE #3</th>
</tr>
</thead>
</table>

### Other

**LIST VACCINE NAME:**

<table>
<thead>
<tr>
<th>DOSE #1</th>
<th>DOSE #2</th>
<th>DOSE #3</th>
<th>DOSE #4</th>
</tr>
</thead>
</table>

***SIGNING PROVIDER IS VERIFYING ALL DATES ABOVE ARE ACCURATE***

**Provider Name (Please Print):**  
**Address:**  
**Phone:**  
**Date:**  

**Signature:**  
**Clinical or Organization Stamp:**

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