Student Life
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Washington Adventist University
IMMUNIZATION RECORD

Please indicate legibly below the dates the following immunization were given. Attach supporting documents (photocopies) if examining health care provider is not the person who administered vaccines. Unless verified by a health care provider, a statement that the student has acquired immunity through having had a particular disease is not acceptable.
(This is a federal and state guideline for immunization policy.)

DTP (diphtheria, tetanus, pertussis)- Series usually given in infancy and childhood.
TD (tetanus, diphtheria)- Given in adulthood every ten years after initial childhood DTP series.
MMR (measles, mumps and rubella)- Two doses are needed in childhood (no earlier than 12 months of age or closer together than one month.) Persons born before 1957 are considered immune.
Polio – Series usually given in infancy and childhood.
Meningococcal (meningitis)- Required by the state of Maryland by students in on campus housing unless waiver is signed.
Hepatitis B- Given to adults in three doses. The 2nd dose is given one month after the 1st dose. The 3rd dose is usually given 6 months later, but no sooner than 2 months after the 2nd dose.
Varicella (chickenpox)- Immunity can be shown by a positive titer. If titer does not demonstrate immunity, then two doses of vaccine are required.

Dates of Vaccines

Dose No.	DTP	TD*	Polio	MMR*	Meningococcal	Hep. B**	Varicella**
1							
2							
3							
4							
5							
6							

*Required for all students. **Required for nursing and respiratory care students, recommended for all students.

Titers/1GG Only

Disease	Results	Immune: YES	NO
1			
2			
3			

_____ _____
Signature of health care provider (administration/verification) **Date**

AUTHORIZATION TO TREAT MINORS

The following permit must be signed by parent/guardian and notarized by a notary public, if the student is under 18 years of age: I hereby authorize and give consent to the health authorities or any licensed health care provider of Washington Adventist University to perform upon or administer to my son/daughter) _____any necessary medical or surgical treatment, examination, vaccines or anesthetics. In the event of any major medical or surgical problem, the University will attempt to contact me by phone or mail prior to the use of this authorization. It is not intended that any of the above mentioned services will be rendered to my son/daughter without his/her consent unless unable to do so (unconsciousness, etc.). This permit is valid only while the student is attending WAU and until he/she reaches the age of 18.

_____ _____ _____
Name (Print) Signature Date
Address_____Phone _____

Witness(Print)_____ Signature _____