

TO BE COMPLETED & SIGNED BY A  
HEALTH CARE PROVIDER

**IMMUNIZATION RECORD**  
Physician/Health Care Provider  
Complete This Form

Garrison-Foster Health Center  
Colby College  
4460 Mayflower Hill Drive  
Waterville, ME 04901-8844  
FAX: (207) 859-4475  
Telephone: (207) 859-4460

All dates must include Month, Day & Year. A titer which shows immunity to Measles, Mumps, Rubella is acceptable, however, history of illness is not acceptable.

**RETURN BY JULY 15<sup>th</sup>**

Maine State law and Colby College policy mandate that your health record, including certification of immunizations, be on file at the Health Center. Immunization records must be complete, showing **month, day** and **year** that immunizations were given and must include the signature or initials of the health care provider and the name and address of the provider's office. Alternatively, a valid copy of school immunization records, hospital/clinic or military records, etc. is acceptable. The State of Maine is very clear that the letter of the law must be followed; if proper proof cannot be obtained, you have these options:

1. A serum titer test can be done for Measles, Mumps, and Rubella. There is no titer test for Tetanus-diphtheria or Polio.
2. Vaccines can be administered again by your home health care provider.

In many cases valid records from many years ago are no longer available; we recognize the inconvenience this causes in some cases, but we must firmly enforce these requirements.

Student's Last Name	First Name	Middle Initial	Date of Birth
			Month Day Year

**HEALTH CARE PROVIDER MUST COMPLETE THE FOLLOWING:**

**A. TETANUS-DIPHTHERIA**

1. Primary series \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. Tetanus-diphtheria (Td) booster **REQUIRED** within the last 10 years. . . . . \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**OR** Tetanus, Diphtheria, Pertussis (Tdap) booster within last 10 years. . . . . \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**B. MMR (Measles, Mumps, Rubella), 2 DOSES REQUIRED**

1. MMR **dose #1** (Immunized after 1st birthday). . . . . \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. MMR **dose #2** (Immunized at least one month after 1<sup>st</sup> dose) . . . . . \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**OR** 3. MEASLES (RUBEOLA) – If given instead of the MMR vaccine, **2 doses required after 1<sup>st</sup> birthday with dose #2 at least one month after dose #1** #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (or copy of laboratory titer)

4. MUMPS – If given instead of the MMR vaccine, **2 doses required after 1<sup>st</sup> birthday with dose #2 at least one month after dose #1** #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (or copy of laboratory titer)

5. RUBELLA – If given instead of the MMR vaccine, **2 doses required after 1<sup>st</sup> birthday with dose #2 at least one month after dose #1** #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ (or copy of laboratory titer)

C. POLIO – **REQUIRED** Oral  IPV  Date Polio primary series completed \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

D. MENINGOCOCCAL VACCINE – **REQUIRED** Menomune  Menactra  \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

E. HEPATITIS B – recommended. . . . . #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

F. HEPATITIS A . . . . . #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

G. HPV – Gardasil . . . . . #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #3 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

H. CHICKEN POX (VARICELLA) VACCINE – Suggested if no history of disease #1 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ #2 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

<b>Physician's Signature</b> _____	<b>Date</b> _____
Physician's Name: _____	Tel: (____) _____
Address: _____	Fax: (____) _____

Forms with incomplete or missing information will be returned for correction. Enclose Health Form and Immunization Record in the business size envelope addressed to COOT and mail with COOT materials by July 15<sup>th</sup>. History and Physical Exam information and Immunization Records are confidential and will be reviewed by Health Center Staff.

**FAILURE TO COMPLY WITH MAINE STATE LAW AND COLBY REQUIREMENTS MAY RESULT IN DENIAL OF COOT TRIP AND/OR REGISTRATION. PROPER COMPLETION, DOCUMENTATION AND RETURN OF ALL HEALTH RECORDS IS REQUIRED PRIOR TO YOUR ARRIVAL.**