Student Immunization Record

In order to maintain the health of all students: public health law requires that students attending postsecondary institutions in the state submit proof of immunization against certain vaccine preventable diseases. Hebrew Union College students may demonstrate immunity by presenting proof of having received two (2) vaccinations for Rubeola (Measles), two (2) vaccinations for Mumps, and at least one vaccination for Rubella (German Measles) or if given in combination, two (2) M-M-R (Measles, Mumps and Rubella) vaccines. Immunity may also be affirmed by providing the results of a laboratory test (immune titer) for each disease.

<table>
<thead>
<tr>
<th>Student’s Name</th>
<th>Date of Birth</th>
<th>Campus</th>
</tr>
</thead>
</table>

### Mandatory Immunizations

**Two Measles Mumps and Rubella (MMR) vaccinations**
- **Date 1:** Immunization on or after first birthday and after January 1, 1957
- **Date 2:** Immunization 15 months after birth and at least 28 days after 1st vaccination
- If born before 1957, indicate birth date

**OR**

**Two Measles (Rubeola) vaccinations**
- **Date 1:** Immunization on or after first birthday and after January 1, 1957
- **Date 2:** Immunization 15 months after birth and at least 28 days after 1st vaccination
- **Date of positive immune titer**

**Rubella (German Measles) vaccination**
- **Date 1:** Immunization on or after first birthday and after January 1, 1957
- **Date 2:** Immunization 15 months after birth and at least 28 days after 1st vaccination
- **Date of positive immune titer**

### Other Vaccines (Recommended by not mandatory for Admission)

**Tetanus, Diphtheria, Pertussis (primary series completed)**
- Last booster (within 10 years)
- **Date**

**Hepatitis A Series**
- First
- Second

**Hepatitis B Series**
- First
- Second
- Third

**Varicella (Chicken Pox) Vaccine**
- Positive immune titer to Varicella
- **Date**

**OR**

**Varicella was diagnosed**
- **Date**

**Polio (if primary series completed, list the last booster)**
- **Date**

**Tuberculosis skin test**
- **Date**
- Result: □ neg □ pos
- If positive, date of chest X-ray
- **Date**
- Result: □ neg □ pos
- If positive, was prophylaxis given? □ yes □ no
- Dates: from ______ to _______

<table>
<thead>
<tr>
<th>Physician Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Physician Stamp</th>
<th>(office stamp required)</th>
</tr>
</thead>
</table>