

Immunization Form for Stanford Medical and Physician Assistant Students See instructions on page 7 for entering collected information and uploading this form through the Vaden Patient Portal at vadenpatient.stanford.edu.

LAST NAME		FIRST NAME		MIDDLE INITIAL		
DATE OF BIRTH (MM/DD/YYYY)			STANFORD UNIVERSITY I	 DENTIFICATION NUMBER (IF KNOV	VN)	
	DO NOT SEND			THIS FORM ONLY.	1005 AFTED #4 DOCS	
MMR 2 DOSES REQUIRED OR INDIVIDUAL VACCINES AS LISTED BELOW		DATE #1 (GIVEN ON OR AFTER 12 MONTHS OF AGE)		DATE #2 (GIVEN 28 DAYS OR MORE AFTER #1 DOSE)		
		-	-OR—			
Measles (Rubeola) 2 DOSES REQUIRED FOR ALL STUDENTS		DATE #1	DATE #2	INCLUE	OR LABORATORY EVIDENCE OF IMMUNITY INCLUDE REPORT (REVACCINATE FOR EQUIVOCAL TITER)	
BORN AFTER 1956 Mumps DOSES REQUIRED FOR ALL STUDENTS		DATE #1	DATE #2	OR LABORATORY EVIDENCE OF IMMUNITY INCLUDE REPORT		
REGARDLESS OF AGE Rubella (German Measles) 1 DOSE REQUIRED FOR ALL STUDENTS		DATE #1		(REVACCINATE FOR EQUIVOCAL TITER) OR LABORATORY EVIDENCE OF IMMUNITY INCLUDE REPORT		
REGARDLESS OF AGE Hepatitis B B DOSES REQUIRED	titis B DATE #1		DATE #3	CREVACCINATE FOR EQUIVOCAL TITE DATE #3 OR LABORATORY EVIDENCE OF IMMUN INCLUDE REPORT		
					R EQUIVOCAL TITER)	
				AND HEP SURFACE ANTIGEN T		
Tetanus-Diphtheria-Pertussis (Tdap) ONE-TIME DOSE AFTER AGE 10		TDAP DATE	Tetanus-Diphthe	eria (Td)	LAST TD BOOSTER DATE	
Varicella (Chicken Pox) 2 DOSES REQUIRED		DATE #1	DATE #2	OR LABORATORY EVIDENCE OF IMMUNITY INCLUDE REPORT (REVACCINATE FOR EQUIVOCAL TITER)		
Hepatitis A		DATE #1		DATE #2		
THE VACCINES LISTED BELOW ARE RE Meningitis ACWY (LIST TYPE)		DATE #1		RIA. PLEASE CHECK WITH YOUR CLINICIAN. DATE #2		
Meningitis B LIST TYPE)		DATE #1	DATE #2	DATE#3 (IFTRUMEMBA)		
HPV (LIST TYPE)		DATE #1	DATE #2	DATE#3		
Pneumococcal		DATE AND TYPE OF VACCINE #1		DATE AND TYPE OF VACCINE #2		
Japanese Encephalitis		DATE #1	DATE #2	DATE #3		
Rabies		DATE #1	DATE #2	DATE #3	DATE #4	
Typhoid		☐ INJECTABLE	☐ ORAL	DATE		
Yellow Fever		DATE				
Primary Polio Series		DATE #1	DATE #2	DATE #3	DATE #4	
Adult Polio Booster		DATE				
Primary Tetanus (DTaP) Series	DATE #1	DATE #2	DATE #3	DATE #4	DATE #5	
Other (LIST HERE)		DATE(S)				
SIGNATURE OF HEALTH PROV	IDER ***S	IGNING PROVIDER IS VERIF	YING ALL DATES ABOVE ARI	E ACCURATE***	DATE	
PHYSICIAN/MEDICAL PROVIDE	ER NAME (PLEASE PRINT OR U	SE CLINIC STAMP)	ADDRESS			

TELEPHONE NUMBER

FAX NUMBER