

IMMUNIZATION FORM

[TO BE COMPLETED, SIGNED AND STAMPED BY THE STUDENT'S PHYSICIAN]

Student's Name: _____ Date of Birth: _____

The following immunizations are required to enroll in a High School in the USA. Incomplete immunizations may result in delayed or denied entry into school upon arrival. **Copy of the student's Immunization Card from home country must be submitted with this form.**

VACCINE	1 st DOSE (MM/DD/YY)	2 nd DOSE (MM/DD/YY)	3 rd DOSE (MM/DD/YY)	4 th DOSE (MM/DD/YY)	5 th DOSE (MM/DD/YY)
Hepatitis B Minimum 3 doses, if 3rd dose was received on or after 2nd birthday					
Polio (tOPV or IPV)* Minimum 3 doses, if 3rd dose was received on or after 4th birthday					
MMR or Measles Minimum 2 doses after 1st birthday				Or date of disease:	
MMR or Mumps Minimum 2 doses after 1st birthday				Or date of disease:	
MMR or Rubella Minimum 2 doses after 1st birthday				Or date of disease:	
Varicella (Chickenpox) Minimum 2 doses after 1st birthday				Or date of disease:	
DTP/DTaP* (Diphtheria, Tetanus, Pertussis) Minimum 4 doses, if 4th dose was received on or after 4th birthday					
Tdap Booster Minimum 1 dose after 11th birthday			Note: Tdap Booster is the adolescent dose that is given after the 7th birthday and recommended between ages 11 and 12. This vaccine is required regardless of other DTaP or DTP vaccine dates.		
COVID-19 Not mandatory for the program. If taken, please list the vaccine dates and brand.				Vaccine brand:	

***ADDITIONAL DETAILS:**

- 1) POLIO:** OPV given prior to April 1st, 2016, will be presumed to be trivalent and therefore may be accepted, regardless of age or country of administration. If 4th dose of Polio vaccine was administered before 4th birthday a 5th dose will be required.
- 2) DTP/DTaP:** Only 4 doses are required if the 4th dose was received on or after 4th birthday and at least 6 months after 3rd dose. In certain situations, an additional dose may be required, up to a maximum of 6 doses.
- 3) MMR and Varicella** Vaccines are live vaccines and must be given on the same day or at least 28 days apart (this rule also applies to live nasal influenza doses).

Physician's Signature: _____

Printed Name: _____

Country: _____ Date: _____

PHYSICIAN'S SEAL

ADDITIONAL VACCINES REQUIRED ONLY IN SPECIFIC STATES:

VACCINE	1 ^a DOSE (MM/DD/YY)	2 ^a DOSE (MM/DD/YY)	3 ^a DOSE (MM/DD/YY)	4 ^a DOSE (MM/DD/YY)	5 ^a DOSE (MM/DD/YY)
Hepatitis A Minimum 2 doses					
Required in: AK, AR, CT, GA, HI, ID, IN, IA, KS, KY, NV, OK, OR, SC, TN, TX, and UT.					
Meningitis - MenACWY or MCV4 Minimum 1 dose on 10th birthday			Note: Only Quadrivalent Meningococcal of these brands will be accepted: Menactra, Menveo, and MenQuadfi. If your country does not offer these brands, you may have to get this vaccine after your arrival in the USA. Some states may require 2 doses.		
Required in: AZ, AR, CT, DE, GA, HI, ID, IL, IN, IA, KS, KY, LA, ME, MD, MI, MN, MO, NV, NJ, NY, NC, ND, OH, PA, RI, SD, TX, UT, VA and WV.					
HPV Minimum 1 dose			Note: Some states may require 2 doses.		
Required in: HI, RI, and VA.					

*Immunization requirements are determined by each state and are subject to change without advance notice.

Has the applicant received the BCG Vaccine? Yes No If yes, date: ____/____/____
All students must provide TB Test results regardless of BCG vaccine status or chest x-ray result. Test must occur within one year of arrival in the U.S. The TB test can be Skin OR Blood test, and physician must complete results below:

TB Skin Test Exam Date: ____/____/____ **TB Blood Test (IGRA) Exam Date:** ____/____/____
Result: Negative Positive Induration: ____ mm **Result:** Negative Positive Borderline Indeterminate

If the test result is positive, borderline, or indeterminate, a chest x-ray report is required. If IGRA test administered, attach official report.

Chest X-Ray Report Exam Date: ____/____/____ **Result:** Normal (Negative) Abnormal (Positive)

PHYSICIAN'S SEAL

Physician's Signature: _____

Printed Name: _____

Country: _____ Date: _____

STUDENT AND NATURAL PARENT'S AGREEMENT:

I hereby certify that I have been informed that I should have all immunizations and tests required for my High School Program done in my home country before I travel. If for any reason I am not able to take all missing immunizations in my home country before departure, I understand I will have to take them in the USA after arrival. I acknowledge that some immunizations are required to start school and having missing immunizations may result in delayed entry in school. I understand that my insurance does not cover the costs of immunizations and that I will be responsible to cover these costs.

Student's Name: _____ Signature: _____

We, the natural parents of the above-named student, herein give our permission for our child to receive any additional immunizations required for school attendance in the USA after arrival.

NATURAL PARENT/GUARDIAN 1:

Full Name: _____

Relationship to student: _____

Signature: _____

Date: ____/____/____

NATURAL PARENT/GUARDIAN 2:

Full Name: _____

Relationship to student: _____

Signature: _____

Date: ____/____/____