Please circle if you are: Residence Hall and/or Athlete

NORTH IDAHO COLLEGE IMMUNIZATION RECORD

Please Print Legibly

Name_____
Last Name First Name Middle Name Phone Number

Permanent Address _____
Street City State Zip Code Country

Today's Date _____Date of Birth___/___/___Student ID Number or last 4 digits of Social Security_____

To Be Completed and Signed By Your Health Care Provider or please attach official immunization record.
All Information must be in English.

Required

A. M.M.R. (Measles, Mumps, Rubella) (Two doses required.)

1. Dose 1 given at age 12-15 months or later……#1 ___/___ (M Y)
2. Dose 2 given at 4-6 years or later, and at least one month after first dose……#2___/___ (M Y)

Required for Residence Hall living and/ or participation in athletics

B. HEPATITIS B (Three doses of vaccine or a positive Hepatitis surface antibody meets the requirement.)

1. Immunization
   a. Dose #1___/___ (M Y) b. Dose #2___/___ (M Y) c. Dose #3___/___ (M Y) or
2. Hepatitis B surface antibody (titer should only be drawn after vaccine series or exposure)
   Date ___/___ (M Y) Result Reactive_____ Non-reactive_____

Additional International Student Requirement

C. POLIO (Primary series in childhood meets requirement; 1 of the three primary series schedules are acceptable.)

1. OPV alone (oral Sabin three doses): ……#1 ___/___ (M Y) #2 ___/___ (M Y) #3 ___/___ (M Y)
2. IPV alone (injected Salk four doses)……#1 ___/___ (M Y) #2 ___/___ (M Y) #3 ___/___ (M Y) #4___/___ (M Y)
3. IPV/OPV sequential……IPV #1___/___ (M Y) IPV #2 ___/___ (M Y) OPV #3___/___ (M Y) OPV #4___/___ (M Y)

D. Tuberculosis Skin Test: **Date:___/___/___** **Result:_____**
(Example: PPD, tine) (Must be within 1 year of entry into U.S.)
If positive PPD, when was your Chest X-ray? **Date:___/___/___** **Result:_____**
(Must be within 1 year of entry into U.S.)

Recommended

E. Meningococcal (One dose---preferably at entry into college for freshmen living in residence halls who wish to reduce their risk of meningococcal disease.)

Quadrivalent polysaccharide vaccine……..Date____/____/____ (M D Y)

F. Tetanus-Diptheria (Primary series with DTaP or DTP and booster with Td in the last ten years meets requirement.)

1. Primary series of four doses with DtaP or DTP:
   #1 ___/___ (M Y) #2 ___/___ (M Y) #3 ___/___ (M Y) #4 ___/___ (M Y)
2. Tetanus-Diphtheria (Td) booster within the last ten years ……..___/___ (M Y)

Health Care Provider Information

Name_____ Signature _____

Address_____

Phone_____Fax_____

Please return form to:

North Idaho College, Student Health Services, 1000 West Garden Avenue, Coeur d'Alene, Idaho 83814
Telephone Number: 208.769.7818 Fax Number: 208.665.5438