

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 \_\_\_\_/\_\_\_\_ b. Dose #2 \_\_\_\_/\_\_\_\_ c. Dose #3 \_\_\_\_/\_\_\_\_ or  
M Y M Y M Y
- 2. Hepatitis B surface antibody (titer should only be drawn after vaccine series or exposure)  
Date \_\_\_\_/\_\_\_\_ Result Reactive \_\_\_\_\_ Non-reactive \_\_\_\_\_  
M Y

**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 \_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_  
M Y M Y M Y
- 2. IPV alone (injected Salk four doses).....#1 \_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_ #4 \_\_\_\_/\_\_\_\_  
M Y M Y M Y M Y
- 3. IPV/OPV sequential.....IPV #1 \_\_\_\_/\_\_\_\_ IPV #2 \_\_\_\_/\_\_\_\_ OPV #3 \_\_\_\_/\_\_\_\_ OPV #4 \_\_\_\_/\_\_\_\_  
M Y M Y M Y M Y

**D. Tuberculosis Skin Test:**

(Example: PPD, tine) Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Result: \_\_\_\_\_  
(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-Diphtheria** (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 \_\_\_\_/\_\_\_\_ #2 \_\_\_\_/\_\_\_\_ #3 \_\_\_\_/\_\_\_\_ #4 \_\_\_\_/\_\_\_\_  
M Y M Y M Y M Y
- 2. Tetanus-Diphtheria (Td) booster within the last ten years ..... \_\_\_\_/\_\_\_\_  
M Y

**Health Care Provider**

Name \_\_\_\_\_ Address \_\_\_\_\_  
Signature \_\_\_\_\_ Phone \_\_\_\_\_

**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