Samford University

International Student Immunization Record

Name____ SID ______________________________
Last *First* *MI* *Preferred Name*

Address ____
Street *City* *State* *ZIP*

Date of Birth____/____/________ Female Male E-Mail:_______________________________________

Enrolling Year ________ Fall Jan Term Spring Summer

M.M.R. (Measles, Mumps and Rubella)
(No immunization required if born before 1957)

M.M.R. (Measles, Mumps, Rubella)	#1 ____________ month/ day/ year	#2 ____________ month/day/year

OR

MEASLES (Rubeola) two doses required OR positive immune titer*
MUMPS one dose required OR report of positive immune titer*
RUBELLA one dose required OR report of positive immune titer*

Measles	#1 ____________ month/day/year	#2 ____________ month/day/year	Titer results and date ____________ *attach report copy
Mumps	#1 ____________ month/day/year	Titer result and date *attach report copy ____________	
Rubella	#1 ____________ month/day/year	Titer result and date *attach report copy ____________	

TETANUS-DIPHTHERIA PERTUSIS
Vaccination must be within the last 10 years

Tdap ____________ month/day/year	OR	Td ____________ month/day/year

TUBERCULOSIS SCREENING:
All international students, regardless of country of origin, must present to University Health Services for tuberculosis risk assessment upon arrival to campus.

VARICELLA (Chickenpox)

Varicella Titer	____________ month/year	
OR Immunization	#1 ____________ month/day/year	#2 ____________ month/day/year

MENINGOCOCCAL QUADRIVALENT

Students < 21 years must have a dose of conjugate vaccine at ≥ 16 years of age	____________ month / day/ year

REQUIRED OF ALL HEALTH SCIENCES STUDENTS *(recommended for all students)*

HEPATITIS B VACCINE

#1 ____________ month/day/year	#2 ____________ month/day/year	**#3** ____________ month/day/year

OR

TITER

Hepatitis B Surface Antibody	____________ month/day/year	Reactive Non-reactive

THIS RECORD MUST BE SIGNED BY A HEALTH-CARE PROVIDER (Health Department stamp is acceptable).

MD/PA/NP/RN Signature ______________________________________ Date ______________________________

Name (print)____ Phone (_______) ______________________

Address ____

COMPLETE ALL DOCUMENTATION AND RETURN TO UNIVERSITY HEALTH SERVICES BEFORE ARRIVAL.

By mail: University Health Services
Samford University
800 Lakeshore Drive
Birmingham, AL 35229

By email: SUHealth@samford.edu (.pdf attachments only)

By fax: 205-726-4042