IMMUNIZATION FORM

Please complete the following information.

Last Name: _____ First Name: _____ MI: ____

Address: _____ City: _____

State: _____ Zip: _____ DOB: _____

Social Security #: _____ Phone: _____

Required for attendance at Lee University. Must be signed by a licensed medical provider.

1. **MMR (measles, mumps, rubella): Documentation of two doses**

   First dose date: ___/___/_____ Second dose date: ___/___/_____

2. **Varicella(chicken pox): At least 28 days between first and second doses**

   First dose date: ___/___/_____ Second dose date: ___/___/_____

   OR

   Titer date: ___/___/_____ Pos.___ Neg.___ Had Disease: Mo.__ Yr._____

Hepatitis B Series for Health Science and Athletic Training Students:

First dose: ___/___/_____ Second dose: ___/___/_____

Third dose: ___/___/_____

RECOMMENDED IMMUNIZATIONS:

TETANUS: ___/___/_____ MENINGITIS: ___/___/_____

LICENSED MEDICAL PROVIDER INFORMATION

PRINTED NAME: _____ DATE: _____

ADDRESS: _____

PHONE: ____-____-_____ SIGNATURE: _____