IMMUNIZATION RECORD

Complete this form and return,
or submit a copy of your immunization record to:
UCA Student Health Clinic
Student Health Building – 1st Floor
201 S. Donaghey Avenue
Conway, AR 72035
Telephone- 501-450-3136 Fax- 501-450-3370

PART I

Name ________________________________ ________________________________ MI ____
Last Name First Name

Address ____
Street City/State/Zip

Date of Birth ___/___/___ Social Security Number __/__/__/-__/__/-__/__/__/__/

Student Status: Part-time ___ Full-time ___ Graduate ___ Transfer ___ International ____

PART II- TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER

All information must be in English

IMMUNIZATIONS REQUIRED BY STATE LAW

M.M.R. (Measles,Mumps,Rubella) 2 Doses Measles, 1 Dose Rubella Required

1. First dose given at age 12-15 months or later ………………………..#1 ___/___/___
Mo. Day Year
2. Second dose given age 4-6 years or later, or 30 days from 1st dose #2 ___/___/____
Mo. Day Year

IMMUNIZATIONS RECOMMENDED
(Not required)

1. **MENINGOCOCCAL** (one dose-preferably at entry into college for freshmen living in dormitories or residence halls who wish to reduce their risk of meningococcal disease.)

   Quadrivalent Vaccine (A,C,Y,W-135) ………………………………………………..____/____/____
   Mo. Day Year
2. **HEPATITIS B** (Three doses of vaccine)
   A. Dose #1 ___/___/___ B. Dose #2 ___/___/___ C. Dose #3 ___/___/___
   Mo. Day Year Mo. Day Year Mo. Day Year
3. **TETANUS/DIPTHERIA** (Booster within the last 10 years)
   Dose ___/____/____
   Mo. Day Year

HEALTH CARE PROVIDER

Name/Title ____ Address ______________________

Signature ______________________________________ Telephone (_____) _________________