University of Lynchburg International Student Immunization Form

Instructions for students:

1. Print the Immunization Form and have it completed and signed by a healthcare professional or an official immunization record from your doctor or another school will be accepted.
2. Log into your Student Health Portal (lynchburg.studenthealthportal.com) and go to the "My Forms" tab, complete the Immunization Form by uploading this completed form through the portal.
3. Complete the required TB assessment and Health History forms on your Student Health Portal under the "My Forms" tab. If screening is positive, take the test form to the provider.

A $200 fine will be applied to your student account if the required health information is not received and completed by the first day of class. Due dates for undergraduate students are January 15th for the Spring semester and July 15th for the Fall semester.

CERTIFICATE OF IMMUNIZATION

This MUST be signed by a healthcare provider

Name (print): _____ **Date of Birth:** ____/____/_____ **Date completed:** ____/____/____

REQUIRED IMMUNIZATION				
Tetanus, Diphtheria (Td) vaccine Or Tetanus, Diphtheria and Pertussis (Tdap)		Date of most recent Tetanus-containing vaccination (Must be within the past 10 years) Circle → Td or Tdap **Date**: (MM/DD/YY) ____/____/____		
Hepatitis B Schedule: 0, 1 month, 6 month	**Date**: (MM/DD/YY) 1)____/____/____	**Date**:(MM/DD/YY) **2**)____/____/____	**Date**:(MM/DD/YY) **3**)____/____/____	**OR Blood Titer** (attach results)
Meningococcal Vaccine (A, C, Y, W) Initial dose OR a booster dose must have been received on or after the 16th birthday	**Date**:(MM/DD/YY) 1)____/____/____	**If applicable, booster > 16 years old** Date: (MM/DD/YY) ____/____/____		
Measles, Mumps, Rubella (MMR) First dose AFTER 1st birthday.	**Date**: (MM/DD/YY) 1)____/____/____	**Date**: (MM/DD/YY) 2)____/____/____	**OR Blood Titer** (attach results)	
Poliomyelitis (OPV) or (IPV) (last dose after the 4th birthday)	**Date**: (MM/DD/YY) 1)____/____/____	**Date**: (MM/DD/YY) 2)____/____/____	**Date**:(MM/DD/YY) **3**)____/____/____	**Date**:(MM/DD/YY) **4**)____/____/____
TB testing only if the screen is positive		Students must complete questionnaire on student health portal under "My Forms"		

STRONGLY RECOMMENDED BUT NOT REQUIRED			
COVID-19 (indicate which vaccine) ☐Pfizer ☐Moderna ☐J&J ☐Other (specify)_____	**Date**:(MM/DD/YY) **1**)____/____/____	**Date**:(MM/DD/YY) **2**)____/____/____	**Date**: (MM/DD/YY) **Booster**)____/____/____
HPV (Quadrivalent or Bivalent) Brand _____	**Date**: (MM/DD/YY) 1)____/____/____	**Date**:(MM/DD/YY) 2)____/____/____	**Date**:(MM/DD/YY) 3)____/____/____
Hepatitis A	**Date**: (MM/DD/YY) 1)____/____/____	**Date**: (MM/DD/YY) 2)____/____/____	
Meningococcal B Vaccine **Brand** _____	**Date**: (MM/DD/YY) 1)____/____/____	**Date**:(MM/DD/YY) 2)____/____/____	**Date**:(MM/DD/YY) 3)____/____/____
Varicella ☐ Had disease **(2 doses one month apart for adults with no history of disease)**	**Date**: (MM/DD/YY) 1)____/____/____	**Date**: (MM/DD/YY) 2)____/____/____	

This form will not be accepted if not signed by a healthcare provider. **HEALTH CARE PROVIDER SIGNATURE (MD, Nurse, NP, PA, DO)**	

Printed Name:_____ Phone:_____

Address:_____

Signature:_____ Date:_____

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