

VIRGINIA MILITARY INSTITUTE

IMMUNIZATION RECORD

This form must be **completed and signed** by the applicant's health care provider.

Applicant's Name: _____ Date of Birth: ____/____/____

REQUIRED: The following immunizations are required for enrollment at VMI.

1. Diphtheria-Tetanus (DTP) or Diphtheria, Tetanus, and Pertussis (DTaP): **(Mandatory)**
Date of completion of childhood series ____/____/____
2. Hepatitis B: **(Mandatory)**
Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____ Date of 3rd dose ____/____/____
3. Meningococcal conjugate or MenACWY vaccines (Menveo®, MenQuadfi®, Penbraya® or PENMENVY®):
(Mandatory – One dose after age 16 required)
Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____
4. Measles-Mumps-Rubella (MMR): **(Mandatory)**
TWO IMMUNIZATIONS REQUIRED. THE FIRST ONE AFTER THE FIRST BIRTHDAY; THE SECOND ONE NO SOONER THAN ONE MONTH LATER OR ANY TIME THEREAFTER.
Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____
5. Poliomyelitis: **(Mandatory)**
Date of completion of primary series ____/____/____
6. Tdap Booster: **(Mandatory)**
Date of last booster ____/____/____ **(Must be within 10 years of matriculation)**
7. Chicken Pox (had disease) Yes____ No____ or Immunization Date(s) Date of 1st dose ____/____/____
(2 doses mandatory if no disease) Date of 2nd dose ____/____/____
8. Tuberculin Test: **(Required for applicants who have lived or traveled extensively overseas)**
Date ____/____/____ Result: (mm induration: _____)
CHEST XRAY RESULTS: (only if POSITIVE) _____
Treatment? _____

RECOMMENDED: The following immunizations are recommended.

If you have not had these vaccines, ask your provider why.

COVID-19 (Highly Recommended)

Indicate which vaccine ☐ Pfizer ☐ Moderna ☐ J&J ☐ Other specify _____

Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____ Date of Booster ____/____/____

Hepatitis A (Recommended)

Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____

HPV (HUMAN PAPILLOMAVIRUS VACCINE) (Highly Recommended)

Applicant had the 2 dose OR 3 dose series

Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____ Date of 3rd dose ____/____/____

Meningococcal B or Serogroup B meningococcal vaccines (Bexsero®, Trumenba®, Penbraya® or PENMENVY®)

Discuss with your provider Applicant had the 2 dose OR 3 does series

Date of 1st dose ____/____/____ Date of 2nd dose ____/____/____ Date of 3rd dose ____/____/____

Nurse/Provider Signature

Nurse/Provider Printed Name

Date

City, State, Zip Code

Area Code & Phone Number