



RESIDENT IMMUNIZATION FORM

Full Name: _____ Social Security: _____ Date of Birth: _____

Address: _____ City/State: _____ Zip: _____

IMMUNIZATION REQUIREMENTS

All students must complete the following vaccination requirements no later than 30 days after moving into the residence hall. Failure to fulfill this requirement may jeopardize your housing assignment. All students must mail or bring in a completed vaccination form, medical history form, and meningitis requirement and waiver form to the Residential Life Office.

IMMUNIZATION HISTORY

The following section must be completed by a health care provider.

MANDATORY IMMUNIZATIONS

The following immunizations are MANDATORY and must be updated or must provide documentation that you have received the required immunization.

Vaccine	Date of Immunization	Date of Immunization	Date of Immunization
Varicella (chicken pox)	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Or confirmed date of disease: ___ / ___ / ___
M.M.R. (Mumps, Measles, Rubella)	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	
Tetanus booster <i>Must be administered within last 10 years.</i>	Dose ___ / ___ / ___	Booster type: <input type="checkbox"/> Td <input type="checkbox"/> Tdap	
Meningitis	Dose ___ / ___ / ___	Vaccination type: _____	
Tuberculin Skin Test <i>Test must be administered within 12 months prior to entering campus housing.</i>	Date read: _____ Induration (mm): _____ Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative A positive TST requires a chest x-ray. Please include chest x-ray radiological report with this form - do not send x-rays. Please complete information below if chest x-ray is administered: Date of chest x-ray: _____ Result: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		

RECOMMENDED IMMUNIZATIONS

The following immunizations are RECOMMENDED but are not required in order to live in the dormitory.

Vaccine	Date of Immunization	Date of Immunization	Date of Immunization
Hepatitis A	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Dose 3 ___ / ___ / ___
Hepatitis B	Dose 1 ___ / ___ / ___	Dose 2 ___ / ___ / ___	Dose 3 ___ / ___ / ___

HEALTH CARE PROVIDER INFORMATION - Must be completed by a health care provider.

Provider Name (Print): _____ Address: _____

Provider Signature: _____ Date: _____ Phone: (____) _____

A completed immunization form and medical history form must be returned to the Residential Life Office no later than 30 days after moving into the residence hall. Please fax to 314-286-3300 or mail these materials to:

Director of Residential Life/Ranken Technical College/4431 Finney Avenue/St. Louis, MO 63113