GOUCHER college

# IMMUNIZATION RECORD

To be completed and signed by a healthcare provider. In lieu of this form, students can upload their official immunization record, provided it includes their name and DOB

STUDENT HEALTH CENTER

1021 Dulaney Valley Rd., Baltimore, MD 21204
Phone: (410)337-6050
Fax: (410)337-6051
Upload completed & signed form to:
https://goucher.medicatconnect.com

Date: _____

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name & Pronouns: _____

Date of Birth: _____ Student ID Number: _____

## Mandatory Immunizations

(Please write the dates on the lines provided and include month, date, and year)

**1. Measles, Mumps, Rubella (MMR):**

Dose 1 (given at 1 year old or later): _____ Dose 2 (given at least 4 weeks after Dose 1): _____

*You may use choose to include a lab report of your titers to satisfy this requirement

**2. Tetanus-Diphtheria:**

*TD booster within the last 10 years

TD: _____ OR Tdap: _____

**3. COVID-19:**

*Goucher requires students receive at least one dose of a COVID-19 vaccination. Additional documentation may be required during their time at Goucher. Please list all of the doses you have received.

Dose 1 Vaccine: _____ Date: _____

Dose 2 Vaccine: _____ Date: _____

Dose 3 Vaccine: _____ Date: _____

Dose 4 Vaccine: _____ Date: _____

**4. Meningococcal:**

*Maryland law requires an individual enrolled in an institution of higher education in Maryland who resides on campus in student housing to receive vaccination against meningococcal disease unless the individual signs a waiver. The waiver can be completed online in the student's Medicat account.

MCV (Menactra/Menveo/Menomune): _____MCV Booster (if initial dose was before age 16): _____

## Recommended Immunizations

Hepatitis B
Dose 1: _____ Dose 2: _____ Dose 3: _____

Hepatitis A
Dose 1: _____ Dose 2: _____ Other: _____

Hepatitis A/B
Dose 1: _____ Dose 2: _____ Dose 3: _____

HPV
Dose 1: _____ Dose 2: _____ Dose 3: _____

Varicella
History of Disease: _____
OR
Dose 1: _____ Dose 2: _____

Meningitis Type B
Dose 1: _____ Dose 2: _____

_____
Provider's Signature Date

_____
Print Name & Title Phone Number

_____
Address