

## Immunization Record Form

**Complete & Fax or Mail:** Stephen F Austin State University  
 Student Health Services  
 PO Box 13058  
 Nacogdoches, TX 75962-3058  
 Fax: (936) 468-1316

*For more information call the clinic at (936) 468-4008*

**Student's Full Name** \_\_\_\_\_

**Campus ID #** \_\_\_\_\_ **DOB** \_\_\_\_\_

**Phone Number (s)** \_\_\_\_\_

**Home address** \_\_\_\_\_

**City, State, Zip** \_\_\_\_\_

IMMUNIZATIONS		DATE(S) GIVEN		
Meningitis Vaccine (Meningococcal Conjugate Vaccine MCV4 or MPSV4)				
Tetanus/ Diphtheria/Pertussis (Tdap) or (Td)				
Oral Polio (IPV) Inactivated Poliovirus Vaccine				
MMR - Measles (Rubeola) (2 doses); Mumps; Rubella				
Hepatitis A Vaccine (HepA)				
Hepatitis B (HepB) (3 doses)				
Varicella Vaccine (Chicken Pox)				
OTHER IMMUNIZATIONS				
Human Papillomavirus Vaccine (HPV)				
TB Skin Test (PPD) or Chest X-Ray	DATE OF LAST TB TEST	DATE OF LAST CHEST X-Ray	TEST RESULTS	
<b>PHYSICIAN / NURSE / PHYSISIAN ASSISTANT / NURSE PRACTIONER:</b>				
Printed Name				
Address				
City, State, Zip				
Physician or Nurse Signature or Facsimile Stamp				