University of Kansas
Watkins Health Services
Upload to: watkinspatientportal.ku.edu
Immunization Compliance
Phone: (785) 864-9533

Immunization History.

Once history is completed by a Physician or Nurse, upload to watkinspatientportal.ku.edu.

Patient Name: (Please print.)

Last:_____ First:_____ Middle:_____

University of Kansas ID Number:_____ Maiden Name/Other Name:_____

Date of Birth:_____ Phone:_____

1. REQUIRED IMMUNIZATION for all newly enrolled or re-enrolled University of Kansas students who were born on or after January 1, 1957:

Measles, Mumps, Rubella (MMR) Vaccine.

#1. Must be no earlier than 4 days before 1st birthday. Format as MM/DD/YYYY.

MMR:_____ OR: Measles:_____ Mumps:_____ Rubella:_____

#2. Must be after 1979 and a least 28 days after 1st MMR. Format as MM/DD/YYYY.

MMR:_____ OR: Measles:_____ Mumps:_____ Rubella:_____

OR: Serological Confirmation of Immunity: *Attach copy of lab report showing both numerical value and reference range.*

2. REQUIRED IMMUNIZATION for all students living in university group housing units:

Meningococcal Meningitis Vaccine. Must receive either MCV4 or MPSV4 to meet requirements. No other meningitis vaccinations are accepted. *Meningitis vaccine must have been administered within past 5 years.* Format as MM/DD/YYYY.

MENVEO® / MenQuadfi® / MENACTRA® MCV4:_____ OR MENOMUNE® -- MPSV4:_____

3. RECOMMENDED IMMUNIZATIONS: (Please report all that patient has received.)

Immunization Name	**Dates Series Received/Other information**
COVID-19	Pfizer-BioNTech: MM/DD/YYYY:_____ MM/DD/YYYY:_____ MM/DD/YYYY:_____ Moderna: MM/DD/YYYY:_____ MM/DD/YYYY:_____ MM/DD/YYYY:_____ Janssen (Johnson & Johnson): MM/DD/YYYY:_____ MM/DD/YYYY:_____

Last:_____ First:_____

University of Kansas ID Number:_____ Date of Birth:_____

Immunization Name	**Dates Series Received/Other information**
Meningococcal Group B Vaccine (This vaccine is not a substitute for #2 Required Meningococcal Meningitis Vaccine listed above.)	*BEXSERO®:* MM/DD/YYYY:_____ MM/DD/YYYY:_____ *OR: TRUMENBA®* MM/DD/YYYY: _____ MM/DD/YYYY:_____ MM/DD/YYYY:_____
DPT/TDAP Primary series Dtap, DPT or Td and booster with Td or Tdap in last 10 years meets recommendation	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ #3. MM/DD/YYYY:_____ #4. MM/DD/YYYY:_____ Date of Last Booster: TD:_____ Or Tdap:_____
Hepatitis A Series	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____
Hepatitis B Series	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ #3. MM/DD/YYYY:_____ Titer Results: MM/DD/YYYY:_____ Attach lab result.
Hepatitis A/B Combined	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ #3. MM/DD/YYYY:_____
Human Papillomavirus (HPV)	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ #3. MM/DD/YYYY:_____ #4. MM/DD/YYYY:_____
Polio Primary childhood series meets recommendation	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ #3. MM/DD/YYYY:_____ #4. MM/DD/YYYY:_____
Varicella (Chicken Pox)	#1. MM/DD/YYYY:_____ #2. MM/DD/YYYY:_____ Titer Results: MM/DD/YYYY:_____ Attach lab result. History of Disease. MM/DD/YYYY:_____

Provider Verification. To the best of my knowledge, the above information is accurate.

Physician/Nurse Signature:_____ Date:_____

Printed Name of Physician/Nurse:_____

Circle one: MD DO PA APRN RN LPN MA

Clinic Name:_____ Phone:_____