

University of Kansas

Watkins Health Services

Upload to: [watkinspatientportal.ku.edu](http://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](http://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 1<sup>st</sup> 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 ACWY. Must receive either MCV4 or MPSV4 to meet requirements. No other meningitis vaccinations are accepted. *Meningitis vaccine must have been administered on or after patient's 16th birthday* . 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: \_\_\_\_\_

<b>Immunization Name</b>	<b>Dates Series Received/Other information</b>
Meningococcal Group B Vaccine (This vaccine is not a substitute for #2 Required Meningococcal Meningitis Vaccine listed above.)	<i>BEXSERO</i> <sup>®</sup> : MM/DD/YYYY: _____ MM/DD/YYYY: _____ <i>OR: TRUMENBA</i> <sup>®</sup> 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: \_\_\_\_\_