Welcome to the University of Hartford!

This University of Hartford Health Form is mandatory and the only form that will be accepted as proof of vaccination. All information must be entered on this form. Entering or stamping “See Attached” may delay the processing of your form. Please make this clear to your healthcare provider’s office when you drop off the form. (A physical is not required)

All students, including transfer, international and those changing from part-time to full-time status, are required to submit this form to Health Services no later than July 15th for the fall semester and December 15th for the spring semester.

Transfer Students: Your health records are not automatically transferred with your academic records from your prior university. You must submit a completed form with all required information as if you were a first time college student.

Failure to provide documentation will block your ability to register, add or drop classes or move into any campus housing.

Please return the completed forms to Student Health Services only
Do not send to other departments or with any other paperwork.

If you encounter any difficulty in getting the required information or you have any questions, please contact our office by phone at 860-768-6601.

Please visit our website at: www.hartford.edu/student_affairs/departments/health_services for more information on the services we offer.

Congratulations on your admission to The University of Hartford!

Mary Norris, Administrative Director
norris@hartford.edu

Demetra Eleftheriou, MD, MPH
# IMMUNIZATION RECORD FOR GRADUATE OR CERTIFICATE PROGRAMS

*This form must be on file prior to start of classes or moving onto campus*

*This is the only form we will accept. Please have your healthcare provider fill out this form.*

Name: ___________________________ Address: ___________________________

UHA ID#: ___________________________

Date of Birth: _______________ □M □F  Home # ___________________________

☐Graduate  ☐Certificate  Cell# ___________________________

**Measles Vaccine:** First dose must have been administered on or after the student’s first birthday, AND must have been administered on or after 1/1/69. The second dose must have been administered on or after 1/1/80. *(Exempt if born before 12/31/56)*

**Mumps Vaccine:** Must have been administered on or after the student’s first birthday.

**Rubella (German Measles) Vaccine:** Must have been administered on or after the student’s first birthday.

### REQUIRED IMMUNIZATIONS

This section must be completed by either a physician or someone operating under the direction of a physician, i.e., school nurse, PA, APRN. Record of Immunizations (month/day/year). *If you have a copy of these records from another institution, you may attach them to this from.*

<table>
<thead>
<tr>
<th>Disease</th>
<th>1\textsuperscript{st} dose (or 1\textsuperscript{st} MMR)</th>
<th>2\textsuperscript{nd} dose (or 2\textsuperscript{nd} MMR)</th>
<th>Lab evidence of immunity</th>
<th>Titer Results</th>
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</thead>
<tbody>
<tr>
<td>Disease history not acceptable</td>
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<tr>
<td>Measles</td>
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<tr>
<td>Mumps</td>
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<tr>
<td>Rubella</td>
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<tr>
<td>Varicella Vaccine</td>
<td>Date #1</td>
<td>Date #2</td>
<td>Disease Hx:</td>
<td>Titer Results</td>
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<td>Date:</td>
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<td>Provider Initials:</td>
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<td>Date:</td>
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<tr>
<td>Meningitis Vaccine</td>
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<td>Date:</td>
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</tbody>
</table>

Living on/in campus housing: ☐ Yes  ☐ No

**Signature of Health Care Provider:** *(MUST BE SIGNED OR STAMPED BY HEALTHCARE PROVIDER)*

Name: ___________________________ Signature: ___________________________

Address: ___________________________ Phone: (_______) ___________________

Fax: (_______) ___________________