St. Andrews University
Attn: Office of Health and Wellness
1700 Dogwood Mile
Laurinburg, NC 28352
Phone: 910-277-5040 / 910-277-5149
Fax: 910-277-5546
Email: SAUhealthforms@sa.edu

Immunization Documentation to Be Completed by Your Physician

____
Patient (Student)Last Name First Name MI Date of Birth

SPECIAL INSTRUCATIONS FOR IMMUNICATION DOCUMENTATION FORM

- Month, date, and year for all immunizations must be documented.
- Please note you must show proof of tetanus immunization—both the initial series and a booster within the last 10 years.
- Only laboratory proof of immunization is acceptable for MMR. History of disease, even from a physician, IS NOT ACCEPTABLE PROOF.
- Any medical exemption from the immunization requirements must be verified in a written statement from your physician.
- All immunization records for international students must be translated into English,

REQUIRED VACCINES: Please indicate Month/Date/Year (xx/xx/xxxx)

DPT, **DT**, or **TD** __________ ____________ ___________ __________ __________
(series of 3 required)

Hepatitis B _________ ___________ ___________

Titer Date: _________Result: __________

MMR (series of 2 required) _________ ___________-OR- Titer Date & Result: ____________(Attach Lab Report)
Polio (oral series of 3 doses) _________ ___________ __________ __________ __________

Tetanus Booster (within the last 10 years) ___________

Tuberculin Skin Test (Required for International Students Only). Not if had BCG; date of BCG: _________
Date of TB Test: _________ **Result:** __________ **Negative:** ___________
Positive mm induration (please describe below):
____
____

Chest X-Ray (Required if TB skin test is positive.) Date: ________ Result: ___________
(Please attach a copy of the report)

RECOMMENDED VACCINES: Please indicate Month/Date1Year (xx/xx/xxxx)

Varicella Series __________ _________

Meningococcal __________ Disease Date: ________ Titer Date: _________ Result: __________

I certify that the above-named student has received the vaccines listed above on the dates specified.
Physician Signature: ____

Please print or stamp physician or facility name, office address, and phone number.

RETURN ALL INFORMATION BEFORE AUGUST 1.

For Office Use Only

Rec'd: _________ Date: ___________

Revised 5/5/2020