Birthwise Midwifery School
Immunization Record

Name of Student: _____DOB _____

This Immunization Record Form is designed to collect information about your current immunization status. This information can be provided to us in several ways. Please indicate the method you will use below:

_____Have your **healthcare provider** give you with a complete record that shows the date of your immunizations and mail, fax, or hand-deliver a paper copy of the complete record to the Birthwise Office.

_____ Immunization records from a **previous educational institution** are acceptable—you will need to request them from the institution and mail, fax, or hand-deliver a paper copy of the complete record to the Birthwise Office.

_____If you do not have a personal immunization record, the **form below** can be used in place of your personal immunization record. The record must have a medical provider's name and address or clinic stamp with provider name and address.

_____If you do not have records at all, you'll need to visit your healthcare provider to **receive the required immunizations**.

_____If you have **declined** any or all immunizations for religious or philosophical reasons, indicate this on the form below.

Please make and keep a copy of your form for future reference. Please do not submit originals. Please complete and return this form BEFORE you arrive on campus.

	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTP (Diphtheria/Tetanus /Pertussis)				
Polio				
MMR (Measles, Mumps, Rubella)				
Hepatitis B Series				
Varicella	Disease Date:			
Influenza				
TB Screening (Tuberculin Skin Test)				
	Result:	Result:	Result:	

_____

Name and credentials of healthcare provide phone number

_____

office address town state zip