



0513505



IMMUNIZATION FORM – ALLIED HEALTH PROGRAMS

STUDENT NAME: _____ STUDENT ID _____

PROGRAM: _____

TETANUS

Date Received: _____

VARICELLA VACCINE OR TITER

Date of Immunization/Disease: _____

Date of Titer: _____

Results: _____

MMR VACCINATIONS

MMR #1 (Date): _____

MMR #2 (Date): _____

Students are required to have a Rubella and Measles Titer (laboratory evidence of immunity) indicating immune status.

Health Care Provider Signature: _____ Date _____

Health Care Provider Printed Name: _____

Health Care Provider Contact Information: _____

Complete and forward to any Student Services Center:

Burlington Center
496 McCanna Pkwy
Burlington, WI 53105

Elkhorn Campus
400 County Road H
Elkhorn, WI 53121

Kenosha Campus
3520 - 30th Avenue
Kenosha, WI 53144

Racine Campus
1001 S. Main Street
Racine, WI 53403