



# INSTRUCTIONS



University: **DePauw University**

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

## ✓ HOW TO COMPLETE THESE FORM(S):

- A licensed healthcare professional **MUST** complete and sign **THESE** forms. **ALL green sections are required.**
- PRINT CLEARLY WITH DARK BLACK INK.** A computer will be reading your forms. Fill in circles completely.
- NO** other forms of documentation will be accepted. (Blue Cards, Yellow Cards, State Immunization Records, etc. are NOT accepted)
- Do not fold, cut, or mark on the border lines of these forms.
- Include the Border Lines in your scanned images.
- Review your forms for completeness and accuracy. Double check **ALL** signatures. **MM/DD/YY date formats.**
- Consult your Healthcare Professional before receiving any of the following immunizations.

**Your records are due by: 9/30/2018**

REQUIRED	RECOMMENDED	OPTIONAL
Required by regulation and /or policy to attend this university.	Recommended for your general well being but NOT required.	Optional information
<p><b>Documents:</b> Immunization Certificate</p> <p><b>Immunization Dates:</b> Varicella (2 doses OR Pos. VZVIGG Titer) Meningococcal (1 dose after the age of 16) Hepatitis B (3 doses OR Pos. Quant. Titer) TDaP Booster (Booster within 10yrs) MMR (2 doses OR Pos. Titer)</p>	<p><b>Immunization Dates:</b> Polio Hepatitis A HPV Influenza Meningococcal B</p>	<p><b>Immunization Dates:</b> Pneumococcal JE - Japanese Encephalitis Yellow Fever Rabies</p>

## ✓ UPLOADING YOUR FORMS:

- Review your forms for completeness and accuracy. **Double check ALL signatures.**
- Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- Upload your completed forms to your account at medproctor.com.
- You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- Check your University Email account regularly for messages from MedProctor regarding incomplete information.

You will be notified via email once your information is successfully verified.

### BE AWARE:

- \* Incomplete/Illegible writing and poor images will be rejected.
- \* Completion of these forms by your due date will help expedite your registration process.

**Do not upload this page.**



DEPAUW  
UNIVERSITY  
Est. 1837

# IMMUNIZATION CERTIFICATE

PRINT CLEARLY WITH DARK BLACK INK.  
This form will be read by a computer.  
Upload to medproctor.com



University: **DePauw University**

Green = Required

Student: \_\_\_\_\_

DOB: \_\_\_\_\_

Blue = Recommended

Black = Optional

**MMR** Measles, Mumps, Rubella **Required**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

**MENINGOCOCCAL** **Required**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

**MENINGOCOCCAL** **Recommended**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

**HEPATITIS B** **Required**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

3rd  M  M  D  D  Y  Y

**HPV** - Human Papillomavirus **Recommended**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

3rd  M  M  D  D  Y  Y

**TDaP** - Booster **Required**

Within 10 yrs.  M  M  D  D  Y  Y

**VARICELLA** - Chicken Pox **Required**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

**HEPATITIS A** **Recommended**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

**POLIO** - Inactivated **Recommended**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

3rd  M  M  D  D  Y  Y

4th  M  M  D  D  Y  Y

**INFLUENZA** **Recommended**

1st  M  M  D  D  Y  Y

**Yellow Fever** **Optional**

One  M  M  D  D  Y  Y

**RABIES** - Pre-Exposure **Optional**

1st  M  M  D  D  Y  Y

2nd  M  M  D  D  Y  Y

3rd  M  M  D  D  Y  Y

**REQUIRED - Immunization History Signature (Please clearly complete ALL and place office stamp at bottom of page.)**

LICENSED CARE PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL		
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

**RECOMMENDED - Tuberculosis Test Results**

<p><b>Tb Skin PPD</b> mm and range <b>REQUIRED</b> (fill bubble)</p> <p>Placed: <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <p>Read: <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <p>actual induration in MM only <input type="checkbox"/> m <input type="checkbox"/> m</p> <ul style="list-style-type: none"> <li><input type="radio"/> 0 mm</li> <li><input type="radio"/> 0 to &lt; 5 mm</li> <li><input type="radio"/> 5 to &lt; 10 mm</li> <li><input type="radio"/> 10 to &lt; 15 mm</li> <li><input type="radio"/> 15 mm or larger</li> </ul>	<b>OR</b>	<p><b>Tb Blood</b> T-Spot QuantiferON <b>Results</b></p> <p>Test <input type="checkbox"/> M <input type="checkbox"/> M <input type="checkbox"/> D <input type="checkbox"/> D <input type="checkbox"/> Y <input type="checkbox"/> Y</p> <ul style="list-style-type: none"> <li><input type="radio"/> Positive</li> <li><input type="radio"/> Negative</li> </ul>
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**Tuberculosis Test Results Signature (Please clearly complete ALL and place office stamp at bottom of page.)**

LICENSED CARE PROFESSIONAL SIGNATURE	PRINT LICENSED HEALTH CARE PROFESSIONAL FIRST AND LAST NAME	SIGNATURE DATE
NON-PARENTAL		
NPI NUMBER <small>not required for U.S. service members or international students</small>	NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL	OFFICE PHONE NUMBER

OFFICE STAMP

