INSTRUCTIONS



University:	MSU							
Student:			OOB:					
HOW TO COMPLETE THESE FORM(S):								
PRINT CLEAF NO other form Do not fold, co Include the B Review your folds Consult your	RLY WITH DARK BLACK IN ns of documentation will ut, or mark on the border order Lines in your scanne orms for completeness an Healthcare Professional be		Fill in circles completely. ation Records, etc. are NOT accepted) IM/DD/YY date formats.					
REC	QUIRED	RECOMMENDED	OPTIONAL					
	ulation and /or policy to this university.	Recommended for your general well being but NOT required.	Optional information					
Documents: Immunization C Immunization MMR (2 doses 0	Dates:	Immunization Dates: Varicella Meningococcal Polio Hepatitis A Hepatitis B TDaP Booster HPV Tb Test Results	Immunization Dates: Pneumococcal Meningococcal B JE - Japanese Encephalitis Typhoid Yellow Fever Rabies					

UPLOADING YOUR FORMS:

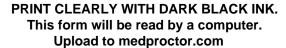
- ☐ Scan or photograph your documents as JPGs for upload. Be sure to include the border lines and fill the picture frame.
- □ Upload your completed forms to your account at medproctor.com.
- ☐ You may upload your additional documentation for storage and later retrieval. (blue cards, state records, etc.)
- □ 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.

IMMUNIZATION CERTIFICATE





University:				G	reen = Required
Student:			DOB:		e = Recommended Black = Optional
MMR Measles, Mumps, Rubella Required 1st 2nd MENINGOCOCCAL Recommended 1st 2nd MENINGOCOCCAL Optional 1st 2nd PNEUMOCOCCAL Optional One PPSV23 PCV13	HEPATITIS B Recommended 1st 2nd 3rd HPV - Human Papillomavirus Recommended 1st 2nd 3rd TDaP / TD- Booster Recommended Within 10 yrs. TDaP / TD	VARICELLA - Chil 1st 2nd HEPATITIS A 1st 2nd POLIO - Inactiva 1st 2nd 3rd 4th	Recommended Recommended Recommended Recommended	Typhoid - Inactivat One Yellow Fever One RABIES - Pre-Expos 1st 2nd 3rd	Optional Optional
REQUIRED - Immunization History	ory Signature (Please clearly con	nplete ALL and	place office stam	p at bottom of pa	ige.)
REQUIRED - Immunization Historican Licensed Care Professional Signature	ory Signature (Please clearly con	15/		p at bottom of pa	
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NON-PARENTAL NPI NUMBER not required for U.S. service members or international stu RECOMMENDED - Tuberculo Tb Skin ppp Placed: Read: actual induration in MM only	PRINT LICENSED HEALTH CARE PROFESSION WHITE STATES AND THE STATES	PAL FIRST AND LAST N	Tb Bloo	SIGNATULE DE PHONE NUMBER T-Spot QuantiFERON	Results O Positive
NON-PARENTAL NPI NUMBER not required for U.S. service members or international stu RECOMMENDED - Tuberculo Tb Skin ppp Placed: Read: actual induration in MM only	PRINT LICENSED HEALTH CARE PROFESSION Desis Test Results mm and range REQUIRED (fill bubble) 0 mm 0 to < 5 mm 5 to < 10 mm 10 to < 15 mm 15 mm or larger	OR L and place off	Tb Bloo Test	SIGNATULE DE PHONE NUMBER T-Spot QuantiFERON	Results Positive Negative

OFFICE STAMP

