

# INSTRUCTIONS

University: **St. Leo 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: Orientation or 8/1/2018 ...whichever comes first!**

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> Meningococcal (1 dose within 5 yrs) 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> Varicella Polio Hepatitis A HPV Tb Test Results</p>	<p><b>Immunization Dates:</b> Pneumococcal Meningococcal B JE - Japanese Encephalitis Typhoid 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.**

# IMMUNIZATION CERTIFICATE



PRINT CLEARLY WITH DARK BLACK INK.

This form will be read by a computer.

Upload to [medproctor.com](https://medproctor.com)

University: **St. Leo University**

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Green = Required

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 B Optional

1st  M  M  D  D  Y  Y  
2nd  M  M  D  D  Y  Y

## PNEUMOCOCCAL Optional

One  M  M  D  D  Y  Y  
PPSV23 ☐ PCV13 ☐

## 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 Recommended

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

## Typhoid - Inactivated Optional

One  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 not required for U.S. service members or international students

NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL

OFFICE PHONE NUMBER

## RECOMMENDED - Tuberculosis Test Results

### Tb Skin PPD

mm and range REQUIRED (fill bubble)

Placed:  M  M  D  D  Y  Y  
Read:  M  M  D  D  Y  Y  
actual induration in MM only  m  m

- ☐ 0 mm
- ☐ 0 to < 5 mm
- ☐ 5 to < 10 mm
- ☐ 10 to < 15 mm
- ☐ 15 mm or larger

OR

### Tb Blood

T-Spot  
QuantIFERON

### Results

Test

M  M  D  D  Y  Y

- ☐ Positive
- ☐ Negative

## 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 not required for U.S. service members or international students

NPI NAME OF LICENSED HEALTH CARE PROFESSIONAL

OFFICE PHONE NUMBER

OFFICE STAMP

