Cumulative Immunization Record
SWOSU Athletic Training

NAME: ____
(Please Print) **Last** **First** **Middle**

DOB: ____________________________ **STUDENT ID:** ____________________________
month/day/year

Immunization	**Date**	**Signature/Title/Facility** (ALL THREE REQUIRED) (may attach copy of original immunization form)
MUST BE COMPLETED BY JUNE 30th		
# 1 Measles/Mumps/Rubella (after 1st birthday)	____________	____________________
# 2 Measles/Mumps/Rubella (at least 1 month after 1st dose)	____________	____________________
FIRST 2 DOSES BY JUNE 30th: THIRD BY NOVEMBER 30th		
#1 Hepatitis B	____________	____________________
#2 Hepatitis B (Due 1 month after 1st injection)	____________	____________________
# 3 Hepatitis B (Due 4 months after 1st injection and 2 months after 2nd injection)	____________	____________________
MUST BE COMPLETED BY JUNE 30TH		
#1 Varicella	____________	____________________
#2 Varicella (Due 4-6 weeks after 1st injection)	____________	____________________
OR		
History of Chickenpox	____________	____________________

MUST BE COMPLETED BY JUNE 30th

NOTE: Booster TB test is required if this is your 1st TB test or if it has been > 1 year since your last test.

TB Skin Testing (completed within the last year)
Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Booster (1-2 weeks after 1st test)
Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Note: Students who have tested positive must submit CXR results, documentation of treatment received and complete an annual sign/symptoms questionnaire in SHS.

Yearly TB Skin Testing (updated annually while in school)

Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Date given: ____________________
Date Read: ____________________
Results: ____________________
Signature/Title: ____________________

Medical History Form
Completed: ____________________

Physical Exam
Completed: ____________________

SEND COMPLETED FORM TO: STUDENT HEALTH SERVICES (SHS) 100 CAMPUS DRIVE WEATHERFORD, OK 73096 or Fax (580) 774-7121