Cumulative Immunization Record SWOSU Exercise Science

NAME:			
(Please Print) Last	First	Middle	
Don	arm.		
DOB: month/day/year	ST	UDENT ID:	
montn/day/year			
		Signature/Title/Facility (ALL THREE REQUIRED) (may attach copy of original immunization form)	
Immunization	Date		
MUST BE COMPLETED BY THE DATE DES	SIGNATED BY THE DEPARTMENT	T OF KINESIOLOGY	
	SIGNATED BY THE DELAKTMENT	OF KINESIOLOGI	
# 1 Measles/Mumps/Rubella (after 1 st birthday)			
# 2 Measles/Mumps/Rubella			
(at least 1 month after 1 st dose)			
FIRST 2 DOSES BY THE DATE DESIGNATE	ED BY THE DEPARTMENT OF KIN	VESIOLOGY	
#1 Hepatitis B			
#1 Hepatitis B			
#2 Hepatitis B			
(Due 1 month after 1st injection)			
#3 Hepatitis B	a and a second		
(Due 4 months after 1st injection and 2 mon	ths after 2" injection)		
MUST BE COMPLETED BY THE DATE DES	SIGNATED BY THE DEPARTMENT	OF KINESIOLOGY	
#1 \$7			
#1 Varicella			
#2 Varicella			
(Due 4-6 weeks after 1st injection)			
OR			
Varicella Titer			
OR			
History of Chickenpox			
MUST BE COMPLETED BY THE DATE DES	SIGNATED BY THE DEPARTMENT	OF KINESIOLOGY	
NOTE: Booster TB test is required if this i	is your 1st TB test or if it has been	> 1 year since your last test.	
TB Skin Testing (completed within	n the last year)	Booster (1-2 weeks after 1st test)	
Date given:		Date given:	
Date Read:		Date Read:	
Results:		Results:	
Signature/Title:		Signature/Title:	
Note: Students who have tested positive mu in SHS.	ıst submit CXR results, documenta	ation of treatment received and complete an annual sign/sym	ptoms questionnaire
Yearly TB Skin Testing (updated a	annually while in school)		
Date given:		Date given:	
Date Read:		Date Read:	
Results:		Results:	
Signature/Title:		Signature/Title:	
Date given:		Date given:	
Date Read:		Date Read:	
Results:		Results:	
Signature/Title:		Signature/Title:	

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