UNIVERSITY of WASHINGTON

GENERAL IMMUNITY REQUIREMENT

This immunization form can be used in place of complete immunization records for the general immunity requirement; for HSIP (Health Sciences Immunity Program) requirements, please see https://www.ehs.washington.edu/health-sciences-immunization-program-hsip. **A signed form is not required if you submit official records**. A medical professional must fill out the bottom portion of this form to verify your required immunizations if you are not submitting official records. Any changes must be initialed and dated.

For more information, including accepted vaccine brands, please refer to our website at immunity.washington.edu. To contact us, please email immunity@uw.edu or call (206) 616-4672. Faxes are accepted at (206) 543-4928.

Official Name (last, first): _____

Date of Birth (Month/Day/Year): _____

Student UW email address: _____@uw.edu **Student ID #:** _____

Required Immunizations	Immunization Dates		
MMR 2 DOSES REQUIRED FOR ALL STUDENTS BORN AFTER 1956, OR INDIVIDUAL VACCINES AS LISTED BELOW	DATE #1 (GIVEN ON OR AFTER 12 MONTHS OF AGE)		DATE #2 (GIVEN 28 DAYS OR MORE AFTER DOSE 1)
------OR------			
Measles (Rubeola) 2 DOSES REQUIRED FOR ALL STUDENTS BORN AFTER 1956	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY **LAB REPORT MUST BE INCLUDED** (REVACCINATE FOR EQUIVOCAL TITER)
Mumps 2 DOSES REQUIRED FOR ALL STUDENTS BORN AFTER 1956	DATE #1	DATE #2	*OR* LABORATORY EVIDENCE OF IMMUNITY **LAB REPORT MUST BE INCLUDED** (REVACCINATE FOR EQUIVOCAL TITER)
Note: Rubella is NOT required			
AND if 16-21 years old			
Meningitis ACWY 1 DOSE CONJUGATE MENINGOCOCCAL ACWY REQUIRED **AFTER 15TH BIRTHDAY** FOR ALL STUDENTS UNDER AGE 22. VACCINES FROM CHINA NOT CURRENTLY ACCEPTED.	DATE #1 (AND BRAND, IF KNOWN)		DATE #2 (AND BRAND, IF KNOWN)—ONLY REQUIRED IF DOSE 1 WAS TAKEN UNDER AGE 15
Note: Meningococcal B is recommended but DOES NOT fulfill this requirement.			

Health Care Professional Verification of Accuracy – Students may not sign their own forms.	
Signature of Licensed Health Care Professional Authorized: CLT, DO, MD, NP, ND, PA, RN, RN-C, RPh	**Date of signature**
Professional Name (print) and License #	**Address and Phone Number OR Office Stamp**

Please submit your immunity documents at immunity.washington.edu

COVID vaccination documents are NOT required.