Azusa Pacific University Health Center
Immunization Record

Immunity is required prior to Registration. Please complete and return.

TO BE COMPLETED BY STUDENT

Name: _____ Date: _____
Last First MI

Date of Birth: _____ Age: _____ Social Security #: _____-_____-_____

Address (Home): _____
Street City State Zip Code

Phone (Home) (____)_____ Cell: (____)_____ __ Male __ Female

TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROFESSIONAL

Tetanus-Diptheria: #1 _____#2 _____ #3 _____ Booster: _____ (within last 10 years), Athletes within 5 years

California requires 2 MMR immunizations

MMR #l _____ MMR #2 _____

TB Skin Test (PPD-Mantoux) within last 12 months -- (Chest xray required if 10 mm or greater) Patient to return in 2 days for skin test evaluation

Date: _____ Date Read: _____ Positive _____mm Negative _____mm
Chest xray: Date _____ Results _____

Hepatitis B: 1) _____ 2) _____ 3) _____ (Required for Nursing students only)

NAME OF HEALTH CARE PROVIDER: _____

Signature: _____ Phone: (___) _____
Address: _____

Return to: Azusa Pacific University Health Center
901 E. Alosta Avenue
Azusa, CA 91702
Phone: (626) 815-2100; FAX: (626) 815-2102

APU Health Center staff will record any/all additional immunizations given in the clinic on the APU Immunization Flow Sheet.

Student's APU Identification Number: 000-_____ HC Rev 2/08