Wesleyan University

STUDENT IMMUNIZATION RECORD

Submit all complete forms and attachments by scanning and uploading them to the student health portal -wesleyan.medicatconnect.com/ Due July 5th 2024.

Last Name:	First Name:	Date of Birth: ___/___/_____ MM DD YYYY	Preferred Name:
Email:	Cell Phone:	Gender Identity:	Wes ID:

REQUIRED VACCINATIONS

Measles, Mumps Rubella MMR Vaccination – required of all students born after 1957

Measles, Mumps, Rubella (MMR) Vaccine - combined	2 doses. Dose #1 on or after 1st birthday. Dose #2 ≥28 days after dose #1.	Dose #1 ___/___/_____ MM DD YYYY	Dose #2 ___/___/_____ MM DD YYYY

OR

If administered separately or proof of immunity by titer. **Copy of lab titer result(s) required.***	2 doses of **measles vaccine** or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ___/___/_____ MM DD YYYY	Dose #2 ___/___/_____ MM DD YYYY	Measles Titer* ☐ Immune ☐ Not Immune Not immune booster required.
	2 doses of **mumps vaccine** or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ___/___/_____ MM DD YYYY	Dose #2 ___/___/_____ MM DD YYYY	Mumps Titer* ☐ Immune ☐ Not Immune Not immune booster required.
	2 doses of **rubella vaccine** or a positive titer. Dose #2 ≥ 28 days after dose #1.	Dose #1 ___/___/_____ MM DD YYYY	Dose #2 ___/___/_____ MM DD YYYY	Rubella Titer* ☐ Immune ☐ Not Immune Not immune booster required.

Meningococcal Vaccine (MenACWY) Vaccination– required of all students living on campus

☐ Menactra ☐ MenQuadfi ☐ Menveo ☐ Nimerex **Must cover strains A, C, Y, W-135. Polysaccharide (MPSV4) vaccine not accepted.**	1 dose if administered ≥ age 16 and within 5 years of the 1st day of classes.	___/___/_____ MM DD YYYY	Exemption to requirement: ☐ I will not be living on campus

Tuberculosis Screening – required if person has lived or traveled outside the United States for greater than 1 month

TB Blood Test/IGRA or TB Skin Test (PPD)		Chest X-ray	Medication Treatment
Recommended if prior BCG ☐ Quantiferon ☐ T-Spot Date: ___/___/_____ MM DD YYYY Result: ☐ Negative ☐ Positive **Copy of lab result required.***	Date administered: ___/___/_____ MM DD YYYY Date read: ___/___/_____ MM DD YYYY mm of induration:	Required if history of current or past positive TB blood or skin test. Not required if completed medication regimen to treat TB. Chest X-ray Date: ___/___/_____ MM DD YYYY ☐ Normal ☐ Abnormal X-ray report must be attached*	☐ Latent TB Infection ☐ Active TB Infection Date(s): _____ List Medication(s):

Varicella Vaccination – required for all students born after 1979

Varicella Vaccine (Chicken Pox) **Copy of lab titer result required.***	2 doses, date of clinician's diagnosis or positive titer. Dose #1 on or after 1st birthday. Dose #2 ≥ 28 days after dose #1.	Dose #1 ___/___/___ MM DD YYYY	Dose #2 ___/___/___ MM DD YYYY	Clinical Diagnosis ___/___/___ MM DD YYYY	Varicella Titer* ☐ Immune ☐ Not Immune Not immune booster required.

RECOMMENDED VACCINATIONS

Adult Tetanus Vaccine	1 dose within 10 years Select Type: ☐ Td ☐ Tdap ***(preferred)***			____/____/____ MM DD YYYY	
Covid-19 Vaccine	1-2 dose series. Booster Dose (bivalent preferred). ☐ Janssen (J&J) ☐ Moderna ☐Novovax ☐ Pfizer ☐ Other (Name of WHO approved vaccine): _____	Dose #1 ____/____/____ MM DD YYYY Brand _____	Dose #2 ____/____/____ MM DD YYYY Brand _____	Booster Dose ____/____/____ MM DD YYYY Brand _____ Monovalent or Bivalent	
Hepatitis A Vaccine	2 doses.	Dose #1 ____/____/____ MM DD YYYY	Dose #2 ____/____/____ MM DD YYYY		
Hepatitis B Vaccine	3 dose series.	Dose #1 ____/____/____ MM DD YYYY	Dose #2 ____/____/____ MM DD YYYY	Dose #3 ____/____/____ MM DD YYYY	Hepatitis B Titer ☐ Reactive ☐ Non-Reactive
HPV Vaccine	2-3 dose series. ☐ Gardasil ☐ Gardasil 9	Dose #1 ____/____/____ MM DD YYYY	Dose #2 ____/____/____ MM DD YYYY	Dose #3 ____/____/____ MM DD YYYY	
Meningococcal B Vaccine	2-3 dose series. ☐ Bexsero ☐ Trumenba	Dose #1 ____/____/____ MM DD YYYY	Dose #2 ____/____/____ MM DD YYYY	Dose #3 (If Trumenba) ____/____/____ MM DD YYYY	
Other					

Health Care Provider Signature/Stamp Required (MD, DO, PA, APRN) OFFICE STAMP

Provider Signature: _____Date:_____

Provider Name (print): _____Phone: _____

Address: _____

Wesleyan Health Portal Instructions

The health portal (https://wesleyan.medicatconnect.com launches for new students in early June 2024. You will need your Wesleyan credentials and password to access the portal. Deadline for submission is July 5, 2024. Please try to forward as soon as possible, particularly if you do not have all of the necessary vaccinations/titers. Health requirement completion can take up to several seeks. Please note that if information remains outstanding and has not been verified, you WILL NOT be able to register for classes.

1. Have your primary care provider complete this form. You may need additional vaccinations or titers. Review to make sure all information is documented and accurate.
2. Go to the student health portal. Enter all dates for vaccinations and titers and upload this immunization form and other attachments. All documentation must be translated in English.
3. Read all email correspondence from Medicat. These alerts are advising you of missing documentation or incorrect information. If you are receiving alerts, you are not cleared to register for classes. Follow provided instructions. Please respond directly through the portal or email healthforms@wesleyan.edu with any questions.
4. If you are unable to obtain any of the required vaccinations prior to your campus arrival, please notify the Davison Health Center at healthforms@wesleyan.edu or call 860.685.2470.