

Immunization Requirements

Duke University Health Science Students (Medical, Doctor of Physical Therapy, Nursing, Physician Assistant, Pathology Assistant, or Ophthalmology Assistant)

In order to attend Duke University, you must comply with North Carolina immunization requirements. Your state or country of origin may have different requirements.

This is a three step process:

1. Complete this form and have it reviewed and signed by your healthcare provider.
2. Submit immunization and health information online at healthydevil.studentaffairs.duke.edu
3. Mail, fax, or scan/email this completed form to Duke Student Health Immunizations:
 DUMC Box 2899, Durham, NC 27710; Fax: 919-681-7386;
 Email: DSHS_Immunizations@mc.duke.edu

Last Name _____ First Name _____ MI _____

Duke Unique ID _____ Date of Birth _____ Sex _____
 mm/dd/yyyy

A. Required Immunizations (Enter Month/Day/Year)

Measles, Mumps, Rubella (MMR)				
Dates of Two Combined Shots	or	Dates of 4 Separate Shots	or	Lab record of Titers
Dose #1 <input style="width: 100%;" type="text"/> mm/dd/yyyy Dose #2 <input style="width: 100%;" type="text"/> mm/dd/yyyy	or	Measles #1 <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="checkbox"/> mm/dd/yyyy Measles #2 <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="checkbox"/> mm/dd/yyyy Mumps #1 <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="checkbox"/> mm/dd/yyyy Mumps #2 <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="checkbox"/> mm/dd/yyyy Rubella <input style="width: 100%;" type="text"/> <input style="width: 100%; height: 20px;" type="checkbox"/> mm/dd/yyyy	or	Measles <input style="width: 100%;" type="text"/> mm/dd/yyyy <input style="width: 100%; height: 20px;" type="text"/> result Mumps <input style="width: 100%;" type="text"/> mm/dd/yyyy <input style="width: 100%; height: 20px;" type="text"/> result Rubella <input style="width: 100%;" type="text"/> mm/dd/yyyy <input style="width: 100%; height: 20px;" type="text"/> result Please attach report of results.
Tetanus – Diphtheria – Pertussis -if booster needed, must be given as Tdap.				
Dates of Primary Series Minimum of 3 Doses			and	Last Booster (must be within last 10 years)
Dose #1 <input style="width: 100%;" type="text"/> mm/dd/yyyy	Dose #4 <input style="width: 100%;" type="text"/> mm/dd/yyyy	Booster <input style="width: 100%;" type="text"/> mm/dd/yyyy		
Dose #2 <input style="width: 100%;" type="text"/> mm/dd/yyyy	Dose #5 <input style="width: 100%;" type="text"/> mm/dd/yyyy	Tdap <input style="width: 100%;" type="text"/> mm/dd/yyyy		
Dose #3 <input style="width: 100%;" type="text"/> mm/dd/yyyy				
Polio				
Date of Most Recent Booster(s)				
<input style="width: 100%;" type="text"/> mm/dd/yyyy	<input style="width: 100%;" type="text"/> mm/dd/yyyy	<input style="width: 100%;" type="text"/> mm/dd/yyyy	<input style="width: 100%;" type="text"/> mm/dd/yyyy	<input style="width: 100%;" type="text"/> mm/dd/yyyy
PPD – Tuberculin Skin Test				
Date given <input style="width: 100%;" type="text"/> mm/dd/yyyy	If Positive, Then →	Chest X-Ray		
Date read <input style="width: 100%;" type="text"/> mm/dd/yyyy		Date <input style="width: 100%;" type="text"/> Please attach a copy of radiology report.		
Results (mm) <input style="width: 100%;" type="text"/>		Date <input style="width: 100%;" type="text"/> mm/dd/yyyy Results <input style="width: 100%;" type="text"/> Do not send actual X-Ray films.		

Hepatitis B	OR	Twinrix (Hep A & B)	AND	Hepatitis B Surface Antibody Titer
Dose #1 <input type="text"/> mm/dd/yyyy		Dose #1 <input type="text"/> mm/dd/yyyy		Date <input type="text"/> mm/dd/yyyy
Dose #2 <input type="text"/> mm/dd/yyyy		Dose #2 <input type="text"/> mm/dd/yyyy		Results <input type="text"/>
Dose #3 <input type="text"/> mm/dd/yyyy		Dose #3 <input type="text"/> mm/dd/yyyy		Please attach report of results.
Varicella (Chicken Pox)				
History of Disease <input type="text"/> mm/dd/yyyy	OR	Varicella Vaccine Dose #1 <input type="text"/> mm/dd/yyyy Dose #2 <input type="text"/> mm/dd/yyyy	AND	Varicella Titer Date <input type="text"/> mm/dd/yyyy Results <input type="text"/>
				Please attach report of results.

B. Recommended Immunizations

Meningitis				
Menactra <input type="text"/> mm/dd/yyyy	OR	Menamune <input type="text"/> m/dd/yyyy		
Hepatitis A				
Dose #1 <input type="text"/> mm/dd/yyyy		Dose #2 <input type="text"/> mm/dd/yyyy		
Gardasil (HPV) is recommended for all female students under age 26				
Dose #1 <input type="text"/> mm/dd/yyyy		Dose #2 <input type="text"/> mm/dd/yyyy		Dose #3 <input type="text"/> mm/dd/yyyy

C. Not Required - Immunizations You May Have Received for Travel

Japanese Encephalitis	Rabies
Dose #1 <input type="text"/> mm/dd/yyyy	Dose #1 <input type="text"/> mm/dd/yyyy
Dose #2 <input type="text"/> mm/dd/yyyy	Dose #2 <input type="text"/> mm/dd/yyyy
Dose #3 <input type="text"/> mm/dd/yyyy	Dose #3 <input type="text"/> mm/dd/yyyy
Typhoid-injection	Yellow Fever
Dose #1 <input type="text"/> mm/dd/yyyy	Dose #1 <input type="text"/> mm/dd/yyyy

Signature of Physician/Healthcare Provider is Required:

Name: (Please Print) _____

Signature: _____ Date: _____

Address/Clinic Stamp: _____

Phone Number: _____