Immunization Requirements
Duke University Undergraduate/Graduate/Professional

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 ______ mm/dd/yyyy		Measles #1 ______ mm/dd/yyyy		Measles ______ mm/dd/yyyy result ____
Dose #2 ______ mm/dd/yyyy		Measles #2 ______ mm/dd/yyyy		Mumps ______ mm/dd/yyyy result ____
		Mumps #1 ______ mm/dd/yyyy		Rubella ______ mm/dd/yyyy result ____
		Mumps #2 ______ mm/dd/yyyy		
		Rubella ______ mm/dd/yyyy		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 ______ mm/dd/yyyy	Dose #4 ______ mm/dd/yyyy		Booster ______ mm/dd/yyyy
Dose #2 ______ mm/dd/yyyy	Dose #5 ______ mm/dd/yyyy		Tdap ______ mm/dd/yyyy
Dose #3 ______ mm/dd/yyyy			

Polio – Required for all students under age 18

Date of Most Recent Booster(s)

______ mm/dd/yyyy	______ mm/dd/yyyy	______ mm/dd/yyyy	______ mm/dd/yyyy	______ mm/dd/yyyy

PPD–Tuberculin Skin Test –Required for International Students from Africa, Asia, or Latin America

	If Positive Then	**Chest X-Ray**
Date given ______ mm/dd/yyyy		
Date read ______ mm/dd/yyyy		Date ______ mm/dd/yyyy Please attach copy of radiology report.
Results (mm) ______	→	Result ______ Do not send actual X-Ray films.

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Last Name ______________________________ First Name _____________________ MI __

B. Required for all undergraduates, recommended for all others

Hepatitis B	**(OR) Twinrix (Hep A & B)**
Dose #1 ________ mm/dd/yyyy	Dose #1 ________ mm/dd/yyyy
Dose #2 ________ mm/dd/yyyy	Dose #2 ________ mm/dd/yyyy
Dose #3 ________ mm/dd/yyyy	Dose #3 ________ mm/dd/yyyy

C. Recommended Immunizations

Hepatitis A

Dose #1 ________ mm/dd/yyyy

Dose #2 ________ mm/dd/yyyy

Meningitis

Menactra	OR	Menamune
________ mm/dd/yyyy		________ mm/dd/yyyy

Varicella (Chicken Pox)

History of Disease	OR	Varicella Vaccine
________ mm/dd/yyyy		Dose #1 ________ mm/dd/yyyy
		Dose #2 ________ mm/dd/yyyy

Gardasil (HPV) is recommended for all female students under age 26

Dose #1 ________ mm/dd/yyyy

Dose #2 ________ mm/dd/yyyy

Dose #3 ________ mm/dd/yyyy

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

Japanese Encephalitis	**Rabies**
Dose #1 ________ mm/dd/yyyy	Dose #1 ________ mm/dd/yyyy
Dose #2 ________ mm/dd/yyyy	Dose #2 ________ mm/dd/yyyy
Dose #3 ________ mm/dd/yyyy	Dose #3 ________ mm/dd/yyyy
Typhoid-injection	**Yellow Fever**
Dose #1 ________ mm/dd/yyyy	Dose #1 ________ mm/dd/yyyy

Signature of Physician/Healthcare Provider is Required:

Name: (Please Print) ____

Signature: ___________________________________ Date: _____________

Address/Clinic Stamp: ____

Phone Number: ______________________________