Bergeron Wellness Center

Immunization Record

SAINT MICHAEL'S COLLEGE FOUNDED 1904

DEADLINE
As soon as possible

RETURN BY MAIL, EMAIL, OR FAX

Saint Michael's College
Attn: Student Health Services
One Winooski Park, Box 259
Colchester, VT 05439
Email: healthservices@smcvt.edu
Fax: +1.802.654.2699

WE WILL ALSO ACCEPT A COPY OF YOUR PROVIDER'S DOCUMENTATION OF VACCINES.

Please Complete the Following:

_____
Last (Family) Name First Name Middle Initial

_____ _____ _____
Birth Date SMC ID# Class Year

Gender (please circle):
Male Female Transgender Non-Binary Prefer Not to Disclose

_____ _____
Preferred Name Preferred Pronoun

Alternate Email: _____

Cell Phone: _____

VERMONT STATE LAW REQUIRES THAT ALL STUDENTS HAVE THE FOLLOWING IMMUNIZATIONS.

THIS PORTION OF THE FORM SHOULD BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER (DOCTOR/NURSE).

Vaccine Against	Dates Given	VT Dept. of Health Requirements
Tdap or Td *Tetanus-Diphtheria-Pertussis*	Tdap Td___ __/__/__ mm / dd / yy	1 Tdap/Td booster within last 10 years *(Tdap preferred)*
MMR *Measles-Mumps-Rubella*	#1 __/__/__ #2 __/__/__ mm / dd / yy mm / dd / yy **OR** Positive Titer* Dates: __/__/__ __/__/__ __/__/__ Measles Mumps Rubella	2 doses or positive titer Minimum of 4 weeks between doses.
Bacterial Meningitis	__/__/__ mm / dd / yy	1 dose given within last 5 years for students living in campus-based housing for anyone under the age of 22.
Varicella *(Chicken Pox)*	1. History of disease: YES _____ NO_____ (if NO, proceed to 2.) 2. Immunization: #1 __/__/__ #2 __/__/__ mm / dd / yy mm / dd / yy **OR** Positive Titer* Date: __ / __/__ mm / dd / yy	2 doses of varicella vaccine, or history of disease, or positive titer.
Hepatitis B	#1 __/__/__ #2 __/__/__ #3 __ / __/__ mm / dd / yy mm / dd / yy mm / dd / yy OR Positive Titer* Date: __ / __/__ mm / dd / yy	
COVID-19	#1 __/__/__ #2 __/__/__ #3 __ / __/__ mm / dd / yy mm / dd / yy mm / dd / yy	While not mandatory, we strongly recommend having a complete and up to date series of the Covid-19 vaccine. Please indicate the dates you received this vaccine.

PLEASE BE SURE TO COMPLETE BOTH SIDES OF THIS FORM >

HEALTH CARE PROVIDED INFORMATION AND SIGNATURE

Name: _____ Phone: _____

Address: _____

Signature: _____