



Vaccine Administration Record for Midwestern University Students

Instructions:

Required fields are indicated with an asterisk (*). For questions, please contact Kamrie Wolf at 623-537-6231 or kwolf@midwestern.edu.

Student Information:

Print Student Name*: _____ Student ID#*: _____

Date of Birth*: _____ Phone*: _____ Program/Year*: _____

Student Signature*: _____

Please Indicate Vaccine(s) Received:

Select the vaccine received and enter all information about the vaccine.

____ TDAP

____ MMR

____ Varicella (Select One)

____ 1st ____ 2nd

____ Hepatitis B (Select one)

____ 1st ____ 2nd ____ 3rd

____ Hepatitis B Booster (Select one)

____ 1st ____ 2nd ____ 3rd

#1 Vaccine*: _____

Manufac.*: _____ Lot #*: _____ Exp. Date*: _____

Date Given*: _____ Site*: _____ Route*: ____ SQ ____ IM

Administers Signature*: _____

#2 Vaccine: _____

Manufac.: _____ Lot #: _____ Exp. Date: _____

Date Given: _____ Site: _____ Route: ____ SQ ____ IM

Administers Signature: _____

Required Healthcare Provider Information and Certification (Cannot be signed by student or non-healthcare provider)

Print Provider Name*: _____

Credentials/Title*: _____

Provider Signature*: _____

Phone*: _____

Fax*: _____