



UNIVERSITY of WISCONSIN
GREEN BAY

Master of Athletic Training

Immunization Record

TO BE COMPLETED AND SIGNED BY YOUR HEALTHCARE PROVIDER OR YOU MAY COMPLETE THIS FORM YOURSELF AND ATTACH COPIES OF OFFICIAL IMMUNIZATION RECORDS.

Name (Last/Family, First, Middle Initial)		DOB	
<ul style="list-style-type: none"> • Measles, mumps, and rubella (MMR) vaccine is not required for students born before January 1957. • Medical reasons for not receiving vaccines report in Part 2. This requires your medical provider's signature. 			
Part 1: Immunization Record		Enter date each immunization was given	
Tetanus, Diphtheria, Pertussis (Tdap) (Report most current) (Month, Day, Year)			
Measles (rubeola, red measles) (Month, Day, Year)	Dose 1	Dose 2	
Mumps (Month, Day, Year)	Dose 1	Dose 2	
Rubella (German measles) (Month, Day, Year)	Dose 1	Dose 2	
Hepatitis B (Month, Day, Year)	Dose 1	Dose 2	Dose 3
<p>For the healthcare professional: Please review the requirements, administer any needed immunizations, and sign below to validate.</p> <p>Signature _____ Date _____</p>			
<p>For the student: I certify that the above information is a true and accurate statement of the dates on which I received the required immunizations. I have attached official records for the required immunizations.</p> <p>Student signature _____ Date _____</p>			
Part 2: Medical Exemption			
<p>Medical exemption: The student named above does not have one or more of the required immunizations because he/she has a medical problem that precludes the _____ vaccine(s), or has shown laboratory evidence of immunity against _____.</p> <p>_____.</p>			
<p>Health Care Provider signature _____ Date _____</p>			