MANIPAL UNIVERSITY

STUDENT IMMUNIZATION RECORD

Proof of immunization or immunity is REQUIRED OF ALL STUDENTS in order to register at the University. Note that a Registered Medical Practitioner must sign the form **OR** you must attach an official certificate from the Health Department. Incomplete forms will be returned.

Name _____ **Date of Birth** _____

Roll Number_____ **Phone number** _____

Institution _____

IMMUNIZATION HISTORY: (This section is to be completed and signed by a registered medical practitioner)

HEPATITIS B

Date: 1) _____ Date: 2) _____ Date: 3) _____

AND

Hepatitis B Antibody Titer: Date: _____ Immune _____ Not Immune _____ Value: _____

VARICELLA (CHICKEN POX):

1st immunization Date: _____ 2nd immunization Date: _____

- OR –

Date of disease (month & year): _____

- OR –

Varicella Titer: Date: _____ Immune _____ Not Immune _____ Value: _____

MUMPS, MEASLES (RUBEOLA), RUBELLA:

1st immunization Date: _____ 2nd immunization Date: _____

- OR –

Mumps Titer: Date: _____ Immune _____ Not Immune _____ Value: _____

Measles Titer: Date: _____ Immune _____ Not Immune _____ Value: _____

Rubella Titer: Date: _____ Immune _____ Not Immune _____ Value: _____

MEDICAL HISTORY:

Allergies _____

Current medications _____

Current medical conditions_____

Significant past medical history_____

Provider Name (Print) _____

Medical Council Registration Number _____

Signature _____ **Date** _____ **Daytime Phone (_____)** _____

Address _____ _____ _____

Street **City/State** **Pin code**

DECLARATION TO BE SIGNED BY THE STUDENT:

I hereby declare that the particulars mentioned in the form are true to the best of my knowledge and belief, and no material information has been concealed or withheld which has a bearing on selection.

Signature of the Student: _____ **Date:** _____

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