IOWA STATE UNIVERSITY
Thielen Student Health Center

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Ames, Iowa 50011
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RECOMMENDED IMMUNIZATIONS - ALL STUDENTS

LAST NAME	FIRST NAME	MIDDLE

DATE OF BIRTH mm/dd/yyyy	UNIVERSITY ID #	SEMESTER START (CHECK ONE):
		☐ FALL ☐ SPRING ☐ SUMMER 20_____

RECOMMENDED IMMUNIZATIONS

VACCINE	BRAND	DOSES/DATES mm/dd/yyyy
COVID-19	Pfizer J&J Moderna Other: _____	
Hepatitis A		
Hepatitis B		
HPV	Gardasil Other: _____	
Influenza (Seasonal) *Most Recent*		
Mumps	*List only if given separate from MMR*	
Rubella	*List only if given separate from MMR*	
Pneumovax	13 20 23	
Polio	OPV IPV	
Tetanus	Td Tdap DtP	
Varicella		
Other:_____		

LICENSED MEDICAL PROVIDER VERIFICATION

Provider Printed Name: First Last _____ **Phone** _____

Provider Signatures/Credentials _____ **Date** _____

Option 2: Attach original documents for immunizations/testing listed above. Original documents must be clearly legible by TSHC staff and include your name and date of birth.