



WPPD MANDATORY IMMUNIZATION HEALTH HISTORY FORM

Name: _____
(Print) Last First

Date of Birth: _____ Student ID# _____ UF Study begins: _____
Month Day Year Semester Year

Phone: (____) _____ Email: _____

Carefully read the instructions before you complete the form. Registration at UF will be blocked until this document is received and acceptable.

A. Immunization Required for ALL Students (See instruction sheet for acceptable vaccine date explanations)

1. MMR (Measles/ Mumps (See "D.") /Rubella)

Dose: 1 [][] [][] 2 [][] [][]
Month Day Year Month Day Year

Or 2. Measles (Rubeola)

Dose: 1 [][] [][] 2 [][] [][] **or**
Month Day Year Month Day Year
Titer/Date - **Attach copy of IGG titer lab report**
[][] [][]
Month Day Year

and 3. Rubella (German Measles) [][] [][] **or**
Month Day Year
Titer/Date - **Attach copy of IGG titer lab report**
[][] [][]
Month Day Year

New Requirements for ALL Students Entering UF

4. Menomune or Menactra (for meningococcal meningitis)

Date: [][] [][] [][] **or** Read information on Instruction sheet and check-off & sign waiver, below.
Month Day Year

_____ I have read the information provided and I decline receipt of vaccine for meningococcal meningitis.

Signature of Student _____ Date _____

Hepatitis B vaccine is mandatory for your acceptance into the Pharm D.

5. Hepatitis B vaccine Dose: 1 [][] [][]
Month Day Year

Dose: 2 [][] [][] Dose: 3 [][] [][]
Month Day Year Month Day Year

or: Attach "IGG" Titer Lab Report results indicating Proof of Immunity

B. Immunizations Required for International Students & Academic Health Programs (Incl. COLLEGE OF PHARMACY)

6. Tuberculosis Skin Test (PPD by Mantoux current within the past year)

Date Placed [][] [][] Date Read [][] [][] Result (Record in mm) NEG POS
Month Day Year Month Day Year

If positive PPD, [][] [][] **Must send copy of**
date of chest x-ray [][] [][] **chest x-ray report!**
Month Day Year

C. Immunization required for many Academic Health Programs (Incl. COLLEGE OF PHARMACY)

7. Varicella (Chicken Pox)

History of Disease [][] [][] **Attach copy of IGG titer lab report**
Month Day Year **or** Titer/Date [][] [][] **or**
Month Day Year

Varivax Dose: 1 [][] [][] 2 [][] [][]
Month Day Year Month Day Year

D. MANDATORY for ALL College of Pharmacy WPPD Students

8. Tetanus/Diphtheria (Booster within last 10 years) Tdap(Tetanus/Diphtheria/Pertussis)

Date: [][] [][] OR Date: [][] [][]
Month Day Year Month Day Year

9. Mumps
Date: [][] [][]
Month Day Year

E. An **OFFICIAL STAMP** from a doctor's office, clinic, or health department **AND** an **AUTHORIZED SIGNATURE** must appear here or this form will not be approved.

Public Health Clinic or Physician (**OFFICIAL STAMP**)

Physician or Authorized Signature

Date

Send or fax form with lab reports prior to registration to:

University of Florida/WPPD Program
Off-Site Admissions Office
2145 MetroCenter Blvd, Suite 400
Orlando, FL 32835-6217

Fax: 352-273-6593
Call: 352-273-6280 with questions

(Updated September 2009)