

Bowdoin College Health Services Immunization Form – Please return by June 16

To maintain the health and safety of the campus community and comply with state laws, Bowdoin needs a verified record of immunizations for every student. This form must be completed and signed by a healthcare provider and uploaded to the Student Health Portal by **June 16**.

| Last Name | First Name | Middle Initial | Date of Birth |
|-----------|------------|----------------|---------------|
| | | | |

| Required Vaccine | Dates Given (Month/Day/Year) | Doses |
|--------------------------------|--|--|
| MMR | #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ | 2 doses |
| Measles | #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ | 1 st dose given after 1 st birthday minimum of 4 weeks between doses |
| Mumps | #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ | May have combined MMR or individual vaccines |
| Rubella | #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ | |
| Meningococcal (ACWY) | Meningococcal ___/___/___ | One dose given at age 16 or older for all incoming students |
| Polio | #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ #4 ___/___/___ | Primary Series |
| Tdap* or TD | Tdap ___/___/___ or Td ___/___/___ | 1 Tdap*/Td Booster within the last 10 years (*preferred due to recent Pertussis outbreaks) |
| Hepatitis B | #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ OR Positive Titer Date: ___/___/___ | 3 doses or positive titer |
| Varicella (Chicken Pox) | #1 ___/___/___ #2 ___/___/___ OR Positive Titer Date: ___/___/___ History of Disease: <input type="checkbox"/> No <input type="checkbox"/> Yes Date: _____ | 2 doses or positive titer or history of disease |

| Recommended Vaccine | Dates Given (Month/Day/Year) | Doses |
|-----------------------|--|--|
| HPV (Gardasil) | #1 ___/___/___ #2 ___/___/___ #3 ___/___/___ | 3 doses or positive titer |
| Covid - 19 | #1 ___/___/___ #2 ___/___/___ Booster ___/___/___ | A one or two dose series and one booster |
| Hepatitis A | #1 ___/___/___ #2 ___/___/___ | 2 doses |

Has student received BCG (Bacillus Calmette-Guerin vaccination)? No Yes Date: ___/___/___

Provider Signature _____ Date: _____
 Printed Name _____ Tel: _____
 Address _____ Fax: _____