

# Duke University Mandatory Immunization Requirement Form for Undergraduates 2023-24

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_

Duke Unique ID: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

## SECTION A: REQUIRED

**FORMS ARE DUE: JUNE 15 for fall admission, DECEMBER 15 for spring admission. INFORMATION MUST BE IN ENGLISH.**

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
<b>DTaP/DTP/Td</b> (All students must submit documentation of 3 doses of tetanus. One MUST be a Tdap. One must be within the last 10 years.)					
<b>Tdap</b>					
<b>MMR</b> (Measles, Mumps, Rubella) 2 MMR vaccines required on or after first birthday <b>OR</b> positive titers (lab reports must be attached)					
<b>Measles</b> (single antigen 2 required on or after first birthday)					
<b>Mumps</b> (single antigen 2 required on or after 19 first birthday)					
<b>Rubella</b> (single antigen 1 required on or after first birthday)					
<b>Hepatitis B</b> (Complete series required if born on or after 7/1/94. The state of NC does not accept titers for this requirement. Specify vaccine type and list dates below.)					
<b>Engerix-B</b> (3 doses required) <b>OR</b>					
<b>Heplisav-B</b> (2 doses required)					
<b>Meningococcal ACWY</b> (Booster required after age 16.)					
<b>Varicella (chickenpox)</b> (One of the following is required if born on or after April 1, 2001.)					
<b>Varicella vaccine</b> (2 doses required on or after first birthday) <b>OR</b>					
<b>Varicella IgG positive titer</b> (lab report must be attached)					
<b>Polio</b> (Complete series required for students under 18 years old.)					
<b>**TB Screening Questionnaire must be completed online: <a href="https://redcap.duke.edu/redcap/surveys/?s=CEYNR3DPN9">https://redcap.duke.edu/redcap/surveys/?s=CEYNR3DPN9</a></b> <b><u>AFTER COMPLETION, PRINT AND SUBMIT WITH THIS FORM.</u></b> Attach testing/treatment if applicable.					

## SECTION B: OPTIONAL (NOT REQUIRED)

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
<b>COVID-19</b> (WHO approved series and booster recommended) *** subject to change***	Brand			
<b>Meningococcal B</b> (This does not fulfill the Meningococcal ACWY requirement above.)				
<b>Bexsero</b> <b>OR</b>				
<b>Trumenba</b>				
<b>HPV</b> (Gardasil 4 or Gardasil 9)				
<b>Twinrix</b> (Hepatitis A/B combination)				
<b>Hepatitis A</b>				
<b>Ixiaro</b> (Japanese Encephalitis)				
<b>Typhoid</b> (specify vaccine)		Oral		IM
<b>Yellow Fever</b>				
<b>Rabies</b>				

Provider Name (print) \_\_\_\_\_ Title \_\_\_\_\_ Date \_\_\_\_\_  
 Provider Signature \_\_\_\_\_ Office Phone # \_\_\_\_\_  
 Address/Official Stamp \_\_\_\_\_

**Official stamp with authorized signature from MD, DO, PA, NP, RN or LPN required.**

**DUKE DOES NOT ACCEPT FORMS SIGNED BY FAMILY MEMBERS**

Upload to the Student Health Gateway: <https://shc.duhs.duke.edu>

or

Fax to: 919-681-7386