MEREDITH COLLEGE

Raleigh, North Carolina

STUDENT IMMUNIZATION RECORD

5 STUDENT HEALTH CHECKLIST

- **Please have a healthcare provider complete and sign this form.**
- **Once completed, please upload to the Meredith College Student Health Portal at meredith.studenthealthportal.com.**
- **Fall deadline for all forms: July 1**
  Spring deadline for all forms: December 1

Last Name _____ First Name _____ MI ___ Date of Birth_____

- The North Carolina immunization law requires that students entering college present to the school proof of certain required immunizations. The college may have required vaccines in addition to the state requirements. To review the state requirements, go to *immunize.nc.gov/schools/collegesuniversities.htm.*
- Please note that if this requirement is not met, dismissal from school 30 days after registration is mandatory under the law.
- Please review the form to ensure you have met the minimum immunization requirements before submiting your form in the portal.

This form must be completed and signed by a healthcare provider.

SECTION A Required Immunizations

Vaccine	Date/Year	Date/Year	Date/Year
DTP (Date of series required)	#1	#2	#3
Tdap **(Booster within ten years required)**	#1		
Polio (required if under 18 years of age)	#1	#2	#3
Hepatitis B (required if born after 7/1/94)	#1	#2	#3
Measles (Rubeola) on or after 1st birthday	#1	Booster required: #2	
Mumps	#1	Booster required: #2	
Rubella (German measles)	#1		
Meningococcal ACWY (required if born after 1/1/2003)	#1	#2 (if indicated)	
Varicella/Chicken Pox (required)	#1	#2	

If needed, please upload titer lab reports within the immunization section of the online student health portal.

SECTION B Recommended Immunizations

Vaccine	Date/Year	Date/Year	Date/Year
Meningococcal B	#1	#2	
Gardasil - HPV	#1	#2	#3
Hepatitis A	#1	#2	
COVID-19 Prime Series **Please circle**: Pfizer, Moderna, J&J, Novavax	#1	#2	
Covid-19 Booster (monovalent) **Please circle**: Pfizer, Moderna, J&J, Novavax	#1	#2	
COVID-19 Booster (bivalent) **Please circle:** Pfizer or Moderna	#1	#2	

X _____ Date ____ / ____ / ____

Signed by a healthcare provider or stamped by the clinic (required per state law)

Print name of provider above Telephone

Office address City State Zip code