HENDERSON STATE UNIVERSITY
IMMUNIZATION FORM

Complete this form and return, or submit a copy of your immunization records to:

Henderson Student Health Center
1100 Henderson Street, HSU Box 7740
Arkadelphia, AR 71999-0001
Fax: 870-230-5064

If you have questions, please call the Student Health Center at 870-230-5102.

PART 1- **To be completed by student applicant**

Date _____

Name _____ Social Security No. - - Date of Birth / /
Last First Middle Initial

Address _____ Telephone ( )
Street City State Zip code Area Code

Student Status: ☐ Freshman ☐ Graduate ☐ Transfer ☐ International

PART II - Must be completed and signed by your health care provider. *All information must be in English.*

IMMUNIZATIONS REQUIRED BY ARKANSAS STATE LAW

M.M.R. (Measles, Mumps, Rubella)

2 doses Measles AND 1 Dose Rubella and Mumps ***Required*** for all **Freshmen & International students**.

1 dose Measles AND 1 Dose Rubella and Mumps ***Required*** for all **Transfer & Graduate students**.

First Dose give at age 12-15 months or later..... Month_____Day_____Year_____

Second Dose give at 4-6 yr., OR 30 days from first dose ..... Month_____Day_____Year_____

or Documented History (month, yr) of positive measles (Rubeola), Rubella, and Mumps titers. (LAB RESULTS MUST BE ATTACHED)

or Physician Document History of having had Rubeola, Rubella, and Mumps (office records Month_____Day_____Year_____)

Re-immunization is necessary when **Rubella** or **Rubeola** or **MMR** was administered **before 12 months of age/or before Jan. 1, 1968.**

RECOMMENDED IMMUNIZATIONS (not required)

Meningococcal (One-dose-preferably BEFORE entry into college) Arkansas Act 1233 requires us to inform you of a bacterial infection known as meningitis. Although meningitis is rare, individuals who live in close proximity to many others, such as in residence halls, have a slightly higher risk of contracting this disease. There is a vaccine available for meningitis and we encourage students living in residence halls to discuss receiving this vaccine with their Health Care Provider.

Conjugate Vaccine (A, C, Y, W-135)..... _____
Month Day Year

Hepatitis B (three doses of vaccine)

A. Dose #1 _____ B. Dose #2 _____ C. Dose #3 _____
Month Day Year Month Day Year Month Day Year

Tetanus/Diphtheria (Booster within the last 10 years)..... _____
Month Day Year

HEALTH CARE PROVIDER

Name/Title_____ Address_____

Signature _____Telephone (_____)_____

If you have questions, please call the Student Health Center at 870-230-5102.
All documentation must be signed by a **Physician** or **authorized Health Care Provider**
or a copy of an *OFFICIAL* immunization record may be attached.

8/12/09