

Immunization Form

Formulario de vacunación

*This form is for your use only and is to be kept with your personal records should a medical need arise.
Please do not return this form to the Madrid Campus.*

Name of Student

Nombre del estudiante

Date of Birth

Fecha de nacimiento

To be completed by a health care provider:

| <u>Vaccine or test</u> Vacuna | <u>Vaccine type</u> Tipo | <u>Date(s)</u> Fecha(s) | <u>Doctor or Clinic</u> Doctor o Clínica |
|--|-----------------------------|--|---|
| Polio (PPV or eIPV) / Polio | | Primary series Booster | |
| Diphtheria, Pertuisis / Difteria | | Primary series | |
| Tetanus / Tétanos | | | |
| (DPT, DT or Td) / Difteria, polio, tétanos | | Booster(s) | |
| Combination MMR / Triple vírica (paperas, sarampión, rubeola) | | 1 st Dose 2 nd Dose | |
| Measles / Sarampión | | 1 st Dose 2 nd Dose | |
| Mumps / Paperas | | | |
| Rubella / Rubeola | | | |
| Meningitis / Meningitis | | Waiver | |
| Other Vaccines / Otras vacunas | | | |
| Tuberculin Test / Test de tuberculina (Mantoux) Result / Resultado | | | |

N.B. Positive skin test requires a separate physician statement documenting absence of active/infectious tuberculosis.

In case of an emergency, you may contact Saint Louis University - Madrid Campus.

En caso de emergencia, se puede poner en contacto con Saint Louis University - Madrid Campus.

Tel: (34) 638 763 758