



Student Health Center

IMMUNIZATION HISTORY FORM

Name: _____ Student ID: _____ DOB: _____

Please send a copy of your immunization records or ask your medical provider to complete the following information or attach a copy of immunization record. If you have any questions, please call Student Health Services at 575-835-5094.

Please give month and year for each:

DPT/DTAP: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____

TDAP/DT BOOSTER: _____ POLIO: 1) _____ 2) _____ 3) _____ 4) _____

MMR: 1) _____ 2) _____ TB: _____ HIB: _____

HEPATITIS B: 1) _____ 2) _____ 3) _____

HEPATITIS A: 1) _____ 2) _____

MENINGOCOCCAL: _____

VARICELLA: 1) _____ 2) _____

HPV: 1) _____ 2) _____ 3) _____

OTHER: _____

Student Signature or Parent/Guardian Signature (if student is under 18) Date

Thank you,
Hanna Quigg, FNP-C
New Mexico Tech Student Health Center