



# WASHINGTON THEOLOGICAL UNION

## MANDATORY IMMUNIZATION FORM

Incomplete information or invalid dates on this form will prevent you from registering for future semesters and a **HOLD** will be placed on your account. Students not in compliance with this law will not be allowed to attend classes.

*Complete this form with your healthcare provider, obtain all required inoculations, and submit the form to the Registrar's Office via mail, fax or drop off.*

The District of Columbia Immunization Law 3-20 requires that **ALL STUDENTS UNDER AGE 26** (except for students who meet statutory requirements for exemption based on religious or medical reason) provide proof of the following vaccinations or proof of immunity prior to registration:

- One Tetanus and Diphtheria** booster given within the past ten years, **and**
- Two** doses of **Measles, Mumps, and Rubella (MMR)** vaccine given after age one and at least 30 days apart, **and**
- Two** doses of **Varicella** (Chickenpox) vaccine received after age one and at least 30 days apart, or a history of Chickenpox (including month and year of disease) verified by a doctor, **and**
- Three** doses of **Hepatitis B** vaccine, dose 2 given 30 days after dose 1, dose 3 given two months after dose 2.
- One Meningococcal (Meningitis)** vaccine is required for students living in on-campus student housing.

[DC Municipal Reg. 22-153]

**RETURN DEADLINES: August 15<sup>th</sup>** for Fall term – **December 15<sup>th</sup>** for Spring term – **June 1<sup>st</sup>** Summer Term

Last Name	First	MI
Home Address		
City	State	Zip Code
Email Address		

Date of Birth (MM/DD/YYYY)
Semester/Year of Entry
Permanent Phone Number
Cell Phone Number

**IMMUNIZATION EXEMPTION Requests:** Students seeking exemption must submit: (1) a letter from a licensed medical clinician stating that immunization is medically inadvisable, or (2) a letter from church clergy stating that immunization violates the student's religious beliefs.

### REQUIRED IMMUNIZATIONS (To be completed by healthcare provider)

- Varicella #1** \_\_\_\_\_ **Varicella #2** \_\_\_\_\_ **OR Date of Chicken Pox Disease** \_\_\_\_\_  
Date Date (Please include titer results) Date
- Hepatitis B #1** \_\_\_\_\_ **Hepatitis B#2** \_\_\_\_\_ **Hepatitis B #3** \_\_\_\_\_  
Date Date Date  
**OR** Attach lab report showing positive immunity \_\_\_\_\_
- MMR#1** \_\_\_\_\_ **MMR #2** \_\_\_\_\_ **OR** Attach lab report showing positive immunity \_\_\_\_\_  
Date Date  
**OR**  
**Measles #1** \_\_\_\_\_ **Measles #2** \_\_\_\_\_ **OR** Attach lab report showing positive immunity \_\_\_\_\_  
Date Date  
**Mumps** \_\_\_\_\_ **OR** Attach lab report showing positive immunity \_\_\_\_\_  
Date  
**Rubella** \_\_\_\_\_ **OR** Attach lab report showing positive immunity \_\_\_\_\_  
Date
- Tetanus/Diphtheria** \_\_\_\_\_  
Date
- Meningococcal Meningitis** \_\_\_\_\_ (Resident students who do not want to be vaccinated against meningitis must  
Date complete a separate waiver form.)

**By signing below, I attest that the required immunizations as stipulated are current and up to date.**

**Licensed Healthcare Provider Signature** \_\_\_\_\_ **Title** \_\_\_\_\_

(Signature stamp is NOT valid)

Print Name \_\_\_\_\_ Date \_\_\_\_\_ Phone \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_