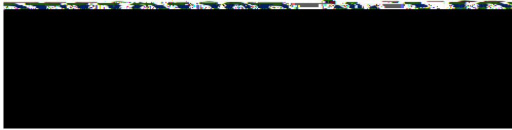

Morehouse School of Medicine Immunization Form

All incoming students must meet certain immunization requirements prior to matriculation. Please have this form completed by your primary care healthcare provider. *Do not send original vaccination records in place of completing this form.* Original records may be attached to this form as supplemental documentation. If for any reason you will not be able to comply with the requirements, please attach a letter of explanation signed by both you and your healthcare provider. For any questions or concerns contact the Student Health and Wellness Center at (404) 756-1241.

Upload this completed form to your Point and Click Patient Portal.

PART I (Completed by the student)

Name (First, Middle and Last): ______________________________

Date of Birth: ______________________________

Address Line 1: ______________________________

Address Line 2: ______________________________

City, State, Zip Code: ______________________________

Date of Entry (MM/YYYY): ________/__________ MSM ID#: ______________

Phone Number: (________)______________________________

Email address (MSM email only): ______________________________

Program (circle one): MPH MSBR MSNS MSCR PhD

PART II REQUIRED VACCINATIONS (Completed by your healthcare provider)

A. COVID-19

1. Dose # 1: ____/____/________ Vaccine Type: ______________________
2. Dose # 2: ____/____/________ Vaccine Type: ______________________
3. Booster: ____/____/________ Vaccine Type: ______________________

B. HEPATITIS B (Complete option 1 or 2)

1. Hepatitis B only

Dose #1 _____/_____/_________ Dose #2 _____/_____/_________ Dose #3 _____/_____/_________

2. Combined hepatitis A and B vaccine

Dose #1 _____/_____/_________ Dose #2 _____/_____/_________ Dose #3 _____/_____/_________

C. INFLUENZA

1. Date of last dose: _____/_____/________

D. MENINENINaC.936.:_-2.6 (aC.MCIC.936.:AL02 0 TdQ(e)-8.6 3 P 02 03R-8 (omIBDC2a (NVin).:AL02 0 Td)1.7(N)-12 (ITMCID