

IMMUNIZATION RECORD FOR UNITED STATES NAVAL ACADEMY PREPARATORY SCHOOL, CLASS OF 2012

Name	SSN	DOB	Phone	Age on June 27, 2011
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By signing below, the appointee and parent/guardian consent for the appointee to receive any additional immunizations required for induction into the Naval Academy Preparatory School. Only the appointee's signature is required when on active duty. The appointee will bring **TWO** completed copies of this form along with any updates to this form on I-Day. Do not mail updates. DO NOT LEAVE IN YOUR BAGS AT I-DAY. Any vaccines not verified on I-day will be given.

Appointee _____ Parent/Guardian _____

******REQUIRED IMMUNIZATIONS: ******

1. Polio (Poliomyelitis) - At least 3 doses are required to complete the series. Adult IPV booster is required for cadets age 17 or older.
2. Tdap is REQUIRED!! DTP, DT, Td - Childhood completion or catch up required per ACIP recommendations.
3. MMR & Varicella - At least 2 doses of each are required. Proof of immunity will be done on I-Day. Do not send proof of immunity.
4. Hepatitis A & B - REQUIRED. NOTE: Indicate if Twinrix, a combination vaccine, was used for HAV and HBV immunizations.
5. Menactra or MENVEO - REQUIRED. Do not give Menomune to meet this requirement. If three years have elapsed since Menomune was given, Menactra or Menveo will need to be given. If five years have elapsed since Menactra or Menveo given, it needs to be repeated.
6. HPV Series for men and women is not required for attendance but highly encouraged. We will offer and/or continue vaccine series at I-Day.

If a provider is uncomfortable with the above guidance, the required vaccines will be administered on I-Day. Any vaccines required will be given on I-Day.

***** THIS SECTION TO BE COMPLETED BY PATIENT'S HEALTH CARE PROVIDER***NO ATTACHMENTS ACCEPTED - Fill out this form. (PRINT)*****

Tuberculin Skin Test (PPD) Provide documentation of a PPD skin test within the last 6 months. If the applicant has a history of a reactive PPD test, documentation of the medical evaluation to include chest x-ray and medication prophylaxis must be provided at I-Day.	Date of PPD _____ Reaction _____ mm (Record in <u>MILLIMETERS ONLY</u> - not "negative" or "positive")
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Polio Mo/Day/Yr	DTP/DTaP Mo/Day/Yr	Tdap Mo/Day/Yr	Gardasil Mo/Day/Yr	Menactra Mo/Day/Yr	Hepatitis A Mo/Day/Yr	Hepatitis B Mo/Day/Yr
1	1		1	1	1	1
2	2		2	2	2	2
3	3	Td Mo/Day/Yr	3	Menveo Mo/Day/Yr		3
4	4	1	Cervarix Mo/Day/Yr	1	MMR Mo/Day/Yr	Varicella Mo/Day/Yr
5	5	2	1	2	1	1
		3	2	Menomune Mo/Day/Yr	2	2
			3	1		

Name _____ Telephone _____ Signature _____ Date _____

This form must be completed and signed by an MD, DO, PA, CNP, or RN. Healthcare Providers may call (410)293-1128/4414 for any questions.

Mail to: ATTN: NAPS Medical, 197 Elliot Street Wing One, Newport, RI 02841. Do not FAX. Due NLT 5 July. Mail one copy and have appointee bring TWO copies of this form to I-Day along with any updates. DO NOT LEAVE IN YOUR BAGS!

*****NAPS IMMUNIZATIONS STAFF ONLY: IDAY REQUIREMENTS***NAPS IMMUNIZATIONS STAFF ONLY: IDAY REQUIREMENTS***REQUIREMENTS*****

Polio (Adult dose after Age 17 required)	Gardasil	TDAP (One dose required)	MENVEO (if Menactra or Menveo ≥ 5 years, if memomune given ≥ 3 years)	PPD (in last 6 months)	HEP A PEDS (1-18YRS)	HEP A ADULT (19 & UP)	HEP B PEDS (0-19YRS)	HEP B ADULT (20 & UP)	TWINRIX (18 & UP)
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Front Table Review Initial _____ Final I-Day Review Signature _____ Updated in AHLTA