



# DISTRICT OF COLUMBIA VACCINATION FORM

District of Columbia law requires that all students attending four-year colleges and universities provide evidence of having received the following vaccinations: measles, mumps and rubella; tetanus, diphtheria and acellular pertussis; Hepatitis B; and Varicella (chickenpox).

If you received regular childhood immunizations, you may have received all of these vaccinations already. You may obtain copies of your immunization records from the doctor or agency that administered the immunizations or, possibly from the elementary or secondary school you attended. If you do not have any record of your vaccinations, your current doctor may test you for immunity to these diseases.

You do not need to comply with this requirement if any of the following apply to you: you are 26 years old or older; you have a medical condition that prevents you from receiving vaccinations; or you have a religious objection to vaccinations.

**PLEASE COMPLETE THIS FORM AND RETURN IT TO THE ADMISSIONS OFFICE PRIOR TO ENROLLMENT.**

\_\_\_\_\_  
Student Name

\_\_\_\_\_  
Student ID Number

\_\_\_\_\_  
Date of Birth

### RECORD OF IMMUNIZATION

Unless you meet one of the exemption categories listed below, please have your doctor complete the following information OR provide copies of an official school immunization record or public health department immunization record.

<b>MMR</b>	<b>Date of First Dose</b>	<b>Date of Second Dose</b> (At least 28 days after first dose)	<b>OR Student has laboratory evidence of immunity to this disease</b> (please initial)
Measles Vaccination			
Mumps Vaccination			
Rubella Vaccination			

<b>Td/Tdap</b>	<b>Date of First Dose</b>	<b>Date of Second Dose</b> (At least 4 weeks after first dose)	<b>Date of Third Dose</b> (At least 6 months after second dose)	<b>Date of Booster Dose</b> (At least 10 years after the primary series if vaccinated in childhood)	<b>OR Student has laboratory evidence of immunity to this disease</b> (please initial)
Tetanus/Diphtheria (Td) or Tetanus/Diphtheria/Acellular Pertussis Vaccination					

<b>Hepatitis B</b>	<b>Date of First Dose</b>	<b>Date of Second Dose</b> (Between 4-8 weeks after first dose)	<b>Date of Third Dose</b> (At least 8-16 after second dose but not earlier than 16 weeks after first dose)	<b>OR Student has laboratory evidence of immunity to this disease</b> (please initial)
Hepatitis B Vaccination				

<b>Varicella</b>	<b>Date of First Dose</b>	<b>Date of Second Dose</b> (At least 28 days after first dose)	<b>OR Student has laboratory or other evidence of immunity to this disease</b> (please initial/describe)
Varicella (Chickenpox)			

**MEDICAL EXEMPTION** - If immunization is medically contraindicated for this student, please indicate the reason(s) why on the back of this form or on an attached page and indicate the specific period of time that the student should not be immunized.

\_\_\_\_\_  
Signature of Doctor Completing this Form

\_\_\_\_\_  
Printed Name of Doctor

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**RELIGIOUS EXEMPTION (to be completed by the student)** - If you object to vaccination requirements on religious grounds, please write a statement on the reverse side of this form or on an attached page indicating why receiving vaccinations conflicts with your religious beliefs.

### CERTIFICATION (all students to sign)

I certify that the above information is true and correct to the best of my knowledge. I understand that if I have not received immunizations due to medical or religious grounds, I may be temporarily excluded from classes and from participating in Strayer University-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak.

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date