

**MANDATORY
IMMUNIZATION
FORM**

RETURN THIS FORM TO:
Student Health Service
2141 K Street, NW • Suite 501
Washington, DC 20037
Phone: 202-994-6827 Fax: 202-973-1572
<http://gwired.gwu.edu/shs>

Due Dates:
August 1st for Fall Enrollment
January 1st for Spring Enrollment

Please Print Legibly

Last Name	First Name	Middle Initial	GW ID: G _____	
			*This is not the # on your GWorld Card	
Email Address			Date of Birth (MM/DD/YYYY)	
Phone Number for the next 45 days			Semester / Year of Entry	Medicine / Allied Health Check Here <input type="checkbox"/>

The District of Columbia Immunization Law requires that ALL STUDENTS, UNDER AGE 26 provide proof of the following immunizations prior to registration. Please note incomplete information, incomplete immunizations or invalid dates on this form will prevent you from registering for the subsequent semester. **Students not in compliance with this law may not be allowed to attend classes.**

Polio ___/___/___ (All students under 18 years of age)

Tetanus/Diphtheria ___/___/___ (Booster in the last 10 years. Tdap recommended)

MMR #1 ___/___/___ (1st dose must be after 12 months of age) **MMR#2** ___/___/___ (Given at least 30 days after dose 1)

-Or-

Measles #1	___/___/___	Measles #2	___/___/___	or attached lab report showing positive immunity
Mumps #1	___/___/___	Mumps #2	___/___/___	or attached lab report showing positive immunity
Rubella #1	___/___/___	Rubella #2	___/___/___	or attached lab report showing positive immunity

Hepatitis B #1 ___/___/___ **Hepatitis B #2** ___/___/___ **Hepatitis B #3** ___/___/___

-Or-

Attached lab report showing positive immunity

Varicella #1 ___/___/___ **Varicella #2** ___/___/___ **OR** Date of Chicken pox disease ___/___

-Or-

Attached lab report showing positive immunity

Meningococcal Vaccine ___/___/___ **Menactra** ___ **Menomune** ___

-Or-

Attached Meningitis Waiver Found at <http://gwired.gwu.edu/shs/ImmunizationRequirement/ImmunizationForm>

Exemptions: Students who meet statutory requirements for exemption based on a religious or medical reason must submit the following:

- 1) This form
- 2) A notarized letter from a clinician or religious clergy which states the need for exemption.

Healthcare Provider Signature, Title Date
Healthcare Provider Phone Number _____

For Office Use Only:	Compliant _____	Non Compliant _____
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