

Corcoran College of Art + Design

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- AFA
 BA
 BFA
 MA

Office Use Only:

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 E-mail Letter V-mail Spoke to Stu/Par

Immunization Record

Section I (To be completed by student)

Last Name	First Name	M.I.	Date of Birth (month/day/year)
Permanent Address (Home)		Local Address (if known)	
Street Address		Street Address	
City/State/Zip		City/State/Zip	
Permanent Phone or Cell		Local Phone or Cell	
E-mail		E-mail	
Person(s) to be notified in an emergency			
Name	Relationship	Phone	
Name	Relationship	Phone	

Student Signature

Date

Section II (To be completed by a physician)

The District of Columbia Department of Health REQUIRES ALL STUDENTS UNDER THE AGE OF 26 to have each of the following immunizations or tests. A titer (blood test for immunity) date may be entered in lieu of vaccination dates.

REQUIRED IMMUNIZATIONS	Date Given (month/day/year)	OR	Date of Positive Titer (attach copy of lab tests)
POLIO (OPV/IPV) Date original series completed, if under 19 years of age	Last Dose		Titer
TETANUS/DIPHtheria (DT/DTP/DTaP/Td) Last booster must be within last 10 years	Last Dose		Titer
MEASLES/MUMPS/RUBELLA (MMR/MMRV) Two doses after first birthday, and at least one month apart	Dose 1		Titer
Or individual -	Measels: _____ Mumps: _____ Rubella: _____	Measels: _____ Mumps: _____ Rubella: _____	Dose 2
HEPATITIS B (Hep B) Three doses: Dose 1, at one month, and at six months	Dose 1		Titer
	Dose 2		
	Dose 3		
VARICELLA (Var) One dose if given before 13 y.o., two doses if given after.	Dose 1		Titer
OR History of disease: <input type="checkbox"/> Yes <input type="checkbox"/> No	Dose 2		
TUBERCULOSIS (Tb) Skin test WITHIN THE PAST SIX MONTHS	Date		Results
If skin test is positive, or if you have had BCG vaccine	Date chest x-ray		Results
MENINGITIS (Recommended by the D.C. DOH and U.S. CDC/P, but NOT REQUIRED)			Dose 1

Physician's Signature (REQUIRED)

Physician's Name (please print)	Physician's Signature
Address	Date
City/State/Zip	Phone