



D.C. IMMUNIZATION REQUIREMENT

D.C. Immunization Law 3-20 requires all students under the age of 26, who are enrolled in a post-secondary school of higher education (college or university), to submit proof of immunization as follows:

- Two (2) doses of Measles, Mumps and Rubella Vaccines (MMR) or a positive blood test for MMR.
- One (1) booster for Tetanus/Diphtheria (Td) within the last 10 years.
- Three (3) doses of Hepatitis-B Vaccines or a positive blood test for Hepatitis-B.
- Two (2) Varicella (Chickenpox) Vaccines if the first dose was given after age 12 or a positive blood test for Varicella.

Possible places for retrieving your immunization records may be your private physician's office. All records must be written in English. If you are missing any of the above vaccines, please obtain that vaccine from your private physician or neighborhood health clinic.

You must submit your immunization forms to the Office of the Registrar before the start of classes for the semester. Any student who does not submit this form, will have a hold placed on their student account which will block registration for the following semester or until the form is turned in. The original must be turned in, copies are not acceptable.

To find a physician's office that provides immunizations, please visit vaccines.gov/getting/where/

Due Date for Students Admitted Fall 2018	August 27, 2018
Due Date for Students Admitted Spring 2019	January 14, 2019

**DANIEL MORGAN GRADUATE SCHOOL OF
NATIONAL SECURITY
2018-2019 MANDATORY IMMUNIZATION FORM**

All dates should be recorded in the mm/dd/yyyy format. Vaccine doses administered up to 4 days before minimum interval or age are counted as valid.

To be completed by the Daniel Morgan Academy Student.			
Last Name	First Name	Initial	Address
Date of Birth (MM/DD/YYYY)			Cell Number
Email Address			Semester and Year of Entry

To be completed by the medical provider.

(Given in the last 10 years, and must be current while the student is enrolled in at the Academy.)
Tetanus/Diphtheria/Pertussis ___ / ___ / ___ or **Tetanus/Diphtheria** ___ / ___ / ___

MMR #1 ___ / ___ / ___ (Given after 1 year of age) **MMR #2** ___ / ___ / ___ (Given at least 30 days after Dose 1) -or-

Measles #1 ___ / ___ / ___ Measles#2 ___ / ___ / ___

Mumps #1 ___ / ___ / ___ Mumps #2 ___ / ___ / ___

Rubella #1 ___ / ___ / ___ Rubella #2 ___ / ___ / ___

-or- immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Hepatitis B #1 ___ / ___ / ___ **Hepatitis B #2** ___ / ___ / ___ (Given at least 4 weeks after Dose 1)

Hepatitis B #3 ___ / ___ / ___ (Given at least 16 weeks after Dose 1; and 8 weeks after Dose 2)

-or- immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Varicella #1 ___ / ___ / ___ **Varicella #2** ___ / ___ / ___ (Given at least 30 days after Dose 1) -or-

History of Disease ___ / ___ (month/year)

-or- immunizations that do not follow the above schedule must be accompanied by a lab report showing positive immunity.

Additional Requirement for Students 17 and under:
Polio#1 ___ / ___ / ___ **Polio #2** ___ / ___ / ___ **Polio #3** ___ / ___ / ___

-or- attach lab report showing positive immunity

Healthcare Provider Signature/Title _____ **Date** _____

OFFICE STAMP of SIGNING CLINICIAN
An Office stamp must be used to validate this form

**- For DMGS Office Use Only: Entered By: Staff Initials: _____ Compliant
 Verified**

Noncompliant: TD/TDap MMR HepB Varicella Polio