TDAP, MENINGOCOCCAL (MCV), VARICELLA (VCV) IMMUNIZATION VERIFICATION

FORM E

Student Information

Last Name/Surname | **First Name** | **Middle Initial**

Date of Birth (mm/dd/yyyy) | **HPU Student ID Number**

This form has been completed to the best of my knowledge, and I freely consent to this information being used for my registration at Hawai'i Pacific University.

Student Signature **Date (MM/DD/YYYY)**

The following is to be completed by a healthcare provider with immunization records attached. Form must be completed in its entirety.

TDAP

Most Recent TDAP Dose		
Month	**Day**	**Year**

VARICELLA (VCV)

COMPLETE THE FOLLOWING:

First Varicella (VCV) Dose		
Month	**Day**	**Year**

Second Varicella (VCV) Dose		
Month	**Day**	**Year**

LIVING ON CAMPUS ONLY

Required for new students planning to live on-campus who are 21 years of age or younger.

MENINGOCOCCAL (MCV)

First Meningococcal (MCV) Dose		
Month	**Day**	**Year**

Name of Physician/Healthcare Professional **Signature** **Date**

U.S. State & License Number **State** **Zip Code**

Hawaii Pacific University
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LOOK CLOSER. SEE FURTHER. DO MORE.