LOMA LINDA UNIVERSITY HEALTH
SAN MANUEL GATEWAY COLLEGE

PRE-ENTRANCE IMMUNIZATION REQUIREMENTS

The following documentation is REQUIRED FOR ALL PROGRAMS and must have either a provider's signature (MD, DO, PA, NP) or be accompanied by a valid, legal immunization record. This documentation must be submitted to the Admission's Office, San Manuel Gateway College. Mail the COMPLETED form to the address below or fax to (909) 558-0433 a minimum of three weeks prior to the beginning of registration. (Populate fillable fields or please print clearly)

Name: _____ _____ _____ Gender: M / F
Last First Middle

Birth Date: _____ / _____ / _____ Phone #: (____) _____
MM DD YYYY

Starting Program / Classes: _____ / _____
Year

Which program you are requesting admission into? _____

REQUIREMENTS	DATE RECEIVED				PROVIDER
MMR (Measles, Mumps, Rubella) ☐ **Submit** documentation of 2 MMR vaccinations given after age 1. --------**OR**--------- ☐ **Submit** positive blood titer reports for **each** disease. Must be **quantitative** (need numerical results) IgG Antibody titers.	**Immunization #1:** (mm/dd/yyyy) _____				
	Immunization #2 (mm/dd/yyyy) _____				
	Date of titer (mm/dd/yyyy)	Measles _____	Mumps _____	Rubella _____	
Tdap (Tetanus, Diphtheria, Pertusis) ☐ Documentation of **Tdap** in the last 10 years ----------**OR**---------- ☐ **Td** in the last 10 years **AND** One dose of Tdap after age 18.	Date of most recent **Tdap**: (mm/dd/yyyy) _____				
	Date of most recent **Td:** (mm/dd/yyyy) _____				
TUBERCULOSIS SCREENING – Refer to: TWO STEP TUBERCULIN SKIN TEST FORM Available from Admissions Office. ☐ **TWO STEP TUBERCULIN SKIN TEST FORM SUBMITTED** Date submitted: _____ (mm/dd/yyyy)					
HEPATITUS B ☐ **Submit** documentation of complete series (3 immunizations required) ----------**OR**---------- ☐ **Submit** positive blood titer report (following vaccine series). Must be **quantitative** (need numerical results) IgG Antibody titer	**Immunization #1** (mm/dd/yyyy) _____				
	Immunization #2 (mm/dd/yyyy) _____				
	Immunization #3 (mm/dd/yyyy) _____				
	Date of Titer: (mm/dd/yyyy)				
VARICELLA (Chickenpox) ☐ **Submit** documentation of 2 Varicella vaccinations given after age 1. ----------**OR**---------- ☐ **Submit** positive blood titer report: Must be **quantitative** (need numerical results) IgG Antibody titer	**Immunization #1** (mm/dd/yyyy) _____				
	Immunization #2 (mm/dd/yyyy) _____				
	Date of Titer: (mm/dd/yyyy) _____				

I certify these immunization records are accurate.

Provider Signature*/Title _____ Date: _____
License Number: _____ State: _____ Phone # _____
*__Please note:__ the provider's signature cannot be dated prior to any dates listed above.