



Morehouse School of Medicine Immunization Form

All incoming students must meet certain immunization requirements prior to matriculation. Please have this form completed by your primary care healthcare provider. *Do not send original vaccination records in place of completing this form.* Original records may be attached to this form as supplemental documentation. If for any reason you will not be able to comply with the requirements, please attach a letter of explanation signed by both you and your healthcare provider. For any questions or concerns contact the Student Health and Wellness Center at (404) 756-1241.

Upload this completed form to your Point and Click Patient Portal.

PART I (Completed by the student)

Name (First, Middle and Last): _____

Date of Birth: _____

Address Line 1: _____

Address Line 2: _____

City, State, Zip Code: _____

Date of Entry (MM/YYYY): ____/____/____ MSM ID#: _____

Phone Number: (____) _____

Email address (MSM email only): _____

Program (circle one): MPH MSBR MSNS MSCR PhD

PART II REQUIRED VACCINATIONS (Completed by your healthcare provider)

A. COVID-19

1. Dose # 1: ____/____/____ Vaccine Type: _____

2. Dose # 2: ____/____/____ Vaccine Type: _____

3. Booster: ____/____/____ Vaccine Type: _____

B. HEPATITIS B (Complete option 1 or 2)

1. Hepatitis B only

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

2. Combined hepatitis A and B vaccine

Dose #1 ____/____/____ Dose #2 ____/____/____ Dose #3 ____/____/____

C. INFLUENZA

1. Date of last dose: ____/____/____

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