



DEPARTMENT OF THE AIR FORCE
10TH MEDICAL GROUP
USAF ACADEMY, COLORADO

Immunization Record Form Instructions
United States Air Force Academy

In order to ensure the health of our Airmen, immunizations are required for entrance into the Academy Prep School. All appointees are required to get the necessary immunizations **PRIOR** to arrival at the Academy. Waivers for immunizations **WILL NOT** be accepted. To avoid unnecessary immunizations, the attached form must be filled out and faxed or emailed to the USAF Academy Immunization Clinic **WITHIN TWO WEEKS OF RECEIPT**. Late appointees will need to fax in this form as soon as possible. All faxes and/or emails must be received **NO LATER THAN 3 JULY 2008**.

Follow these steps when filling out this questionnaire:

- Use a ballpoint pen **only** (no felt tip pens or pencils). **Do not** slash your O's, 7's, or Z's.
- **Part I: To be completed by appointee:**
 - o Fill in Part I **completely**. Please write legibly.
 - o For all dates, **use six digits -- month/day/year**.
 - o If an error is made, **completely cross out the entry and re-write it**.
 - o **Do not** attach original records to this form, as they will not be returned.
- **Part II: To be completed by licensed primary care physician, nurse or immunization technician ONLY.**
 - o Please fill in Part II **completely**.
 - o For all dates, **use six digits -- month/day/year**.
 - o Please ensure each dose is filled in with the **date it was accomplished**.
 - o Any missing vaccines that are not recorded **will be re-administered** upon entrance to the USAF Academy.
- Once record is completed, make two (2) photocopies of the record.
 - o **Keep one for personal record**
 - o **Hand carry one with you on in-processing day.**
- Fax the **original record** to the Academy Immunization Clinic at (719) 333-5448.
If a fax is not available, you may email a copy to:

10MDG.SGOMA@usafa.af.mil

If you would like conformation that your fax or email has been received, please email the clinic at the address listed above. **Please note that ALL immunizations and the Tuberculosis test listed on the form are required for admission. The recommendation is to receive ALL immunizations AT LEAST TWO WEEKS PRIOR to in-processing day.**

Immunizations have a risk of side effects, and some result in sore arms, fatigue, headaches, and other flu like symptoms. Receiving one or more of these vaccinations on the first day of training could result in decreased physical performance during Basic Cadet Training. It takes 4-6 weeks for an immunization to produce an immune response and protect you from disease. Please keep that in mind when scheduling your immunization appointments.

If you have any questions regarding immunizations, please contact the Academy Immunization Clinic Staff by email: **10MDG.SGOMA@usafa.af.mil**.

//SIGNED//
CHARLES N. WEBB, Lt Col, USAF, MC
Director, USAFA Allergy/Immunizations Element

Immunization Record for USAF Academy Prep School Appointees

Part I: To be completed by appointee:
 Completion of all listed immunizations is required for full medical qualification and admission into USAF Academy Prep School. Any vaccinations not received prior to arrival will be given on in-processing day.
Please address any questions regarding this form to the USAF Academy Immunization Clinic by email ONLY.

<input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> Last Name	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> MI	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Gender
<input style="width: 100%; height: 20px; border: 1px solid black;" type="text"/> First Name	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Date of Birth	
<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Home Phone Number	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> Social Security Number	

Email address: _____

Please initial in the box below:

	I understand that all immunizations are required for admission.
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Please authorize the following statement (optional):
 "I authorize the USAF Academy Immunization Clinic to discuss my vaccination history with my parent/guardian."

Signature of Appointee: _____

Part II: To be completed by a licensed primary care physician, nurse or immunization technician ONLY:
 Please ensure each dose is filled in with the date it was accomplished.
 Any missing vaccines that are not recorded will be re-administered upon entrance to the USAF Academy Prep School.

A. Diphtheria, Pertussis and Tetanus Vaccine: Please circle the type and fill in the date of all doses.

<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> #1 (DTaP / DTP / DT)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> #2 (DTaP / DTP / DT)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> #3 (DTaP / DTP / DT)
<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> #4 (DTaP / DTP / DT)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> #5 (DTaP / DTP / DT)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> (DTaP / DTP / DT)

Tetanus and Diphtheria and/or Tetanus, Diphtheria and Pertussis Vaccine:
 If only Td was given, Tdap is required if it has been more than two years since the last Td vaccination.

<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> (Td / Tdap)	<input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> \ <input style="width: 20px; height: 20px; border: 1px solid black;" type="text"/> (Td / Tdap)
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B. **Polio Vaccine:** Please circle the type and fill in the date of all doses.
Must be given within six months of admission (if not a prior active duty military member).

<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>
#1 (OPV / IPV)	#2 (OPV / IPV)	#3 (OPV / IPV)
<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/> \ <input type="text"/> <input type="text"/>
#4 (OPV / IPV)	#5 (OPV / IPV)	(OPV / IPV)

* NOTE: AIR FORCE REQUIRES ALL MEMBERS TO BE GIVEN ONE DOSE OF POLIO WITHIN 6 MONTHS OF ADMISSION.

C. **Measles, Mumps, and Rubella Vaccine (MMR):** Must have at least two doses.

#1 \ \ **#2** \ \

D. **Hepatitis A Vaccine (Hep-A):** Dose #2 must be at least six months from 1st dose.

#1 \ \ **#2** \ \

E. **Hepatitis B Vaccine (Hep-B):** Dose #2 must be at least one month from 1st dose.
 Dose #3 must be at least five months from 2nd dose.

#1 \ \ **#2** \ \ **#3** \ \

F. **Twinrix Vaccine (Hep-A and Hep-B Combination):** **Not necessary if you have received the Hep-A and/or Hep-B series separately.**
 See Section D & E for vaccination schedule.

#1 \ \ **#2** \ \ **#3** \ \

G. **Meningococcal Vaccine (Menomune or Menactra):** Please circle type and fill in the date of dose.

#1 \ \
 (Menomune / Menactra)

H. **Tuberculosis Test (TB Test, IPPD, PPD):** **Required within six months of entrance.**

NOTE: If you have ever had a positive TB test, please fill out questions on the top of the next page.

Date placed: \ \ **Date Read:** \ \

Results: _____ millimeters Circle: Negative / Positive

Have you ever had a positive TB test? YES NO

IF "YES": 1. What was the reaction size? _____ millimeters

2. Was a Chest x-ray performed? YES NO

2 a. Date: _____ (Please Attach Results)

3. Date prophylactic therapy completed (if applicable): _____

OPTIONAL VACCINATIONS:

Varicella Vaccine (Chickenpox):

#1 \ \ #2 \ \

Human Papillomavirus Vaccine (HPV): (Females Only)

Dose #2 must be at least two month from 1st dose.

Dose #3 must be at least four months from 2nd dose.

#1 \ \ #2 \ \ #3 \ \

Signature of Physician/Provider or Nurse: _____

Printed/Stamped Name of Physician/Provider or Nurse: _____

Health Care Provider's Address and Telephone Number: _____

Once record is completed, make two (2) photocopies of the record.

- **Keep one for personal record**
- **Hand carry one with you on in-processing day.**

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