Methodist College
UnityPoint Health

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STUDENT VARICELLA ZOSTER VACINATION/TITER RECORD

Student Name: (Print) ______________________ , ___________________________
Last **First**

Date of Birth: ______________________________

RECORD OF VARICELLA ZOSTER VACCINATION/TITER

Proof of completion must be provided to MC by Physician.

DATE OF VACCINATION:

Dose #1: ________________________ ___________________________________
Health Care Provider Signature

Dose #2: ________________________ ___________________________________
Health Care Provider Signature

***Must be completed 30 days apart.**

In lieu of proof of vaccination, a titer can be done, please enter results below:

TITER RESULTS:

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