The Institute of World Politics
Office of the Registrar
1521 16th Street, NW
Washington, D.C. 20036
202-464-0165 (Fax)

MANDATORY DISTRICT OF COLUMBIA IMMUNIZATION FORM

PART I-TO BE COMPLETED BY STUDENT

Last Name (Print)	First Name (Print)	Middle Initial	Email address

Date of Birth (M/D/Y)	Contact Phone Number	Term of Admission – Semester/Year

The District of Columbia Immunization Law requires that all students under the age of 26 provide proof of certain immunizations prior to registration for classes. Certification of the following immunizations or evidence of positive immunity is required: Tetanus/Diphtheria (Td) or Tetanus/Diptheria/Acellular Pertusis (Tdap), Measles/Mumps/Rubella (MMR), Hepatitis B (HepB), Varicella (Chicken Pox).

Unless you meet one of the exemption categories listed at the bottom of the form, please have your health care provider fill in the dates when you received your immunizations, sign and return this form to IWP at the address listed above. Keep a copy of this for your records.

PART II-TO BE COMPLETED AND SIGNED BY A HEALTH CARE PROVIDER

MMR	Date of First Dose	Date of Second Dose (At least 28 days after first dose)	OR Student has laboratory evidence of Immunity to this disease (please initial)
Measles Vaccination			
Mumps Vaccination			
Rubella Vaccination			

Td/Tdap	Date of First Dose	Date of Second Dose (At least 4 weeks after first dose)	Date of Third Dose (At least 6 months after second dose)	Date of Booster Dose (Must be within 10 years of current date)	OR Student has laboratory evidence of immunity to this disease (please initial/describe)
Tetanus/Diphtheria (Td) or Tetanus/Diptheria/Acelluar Pertussis Vaccination					

Hepatitis B	Date of First Dose	Date of Second Dose (At least 4 weeks after first dose)	Date of Third Dose (At least 16 weeks after second dose)	OR Student has laboratory evidence of immunity to this disease (please initial/describe)
Hepatitis B Vaccination				

Varicella	Date of First Dose	Date of Second Dose (At least 30 days after first dose)	Or Student has laboratory evidence of immunity to this disease (please initial/describe)
Varicella (Chicken Pox)			

_____ _____ _____ _____

Health Care Provider Signature | Printed Name of Health Care Provider | Contact Number | Date

MEDICAL EXEMPTION: If immunization is medically contraindicated for this student, please provide a written, signed, and dated document from a health care provider stating the specific vaccine or vaccines contraindicated and duration or medical condition that contraindicates the vaccine(s).

RELIGIOUS EXEMPTION: A written, signed, and dated document by the student describing his/her objection to immunization on the grounds that they conflict with the tenet and practices of a recognized religious organization, of which the student is an adherent member.

CERTIFICATION (ALL STUDENTS TO SIGN): I certify that the above information is true and correct to the best of my knowledge. I understand that if I have not received immunizations due to medical or religious grounds, I may be temporarily excluded from my classes and from participating in IWP-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak.

_____ _____

Student Signature | Date