

Welcome to Duquesne University!

Completion of the Immunization Verification Form is **REQUIRED** and must be submitted electronically as per the steps outlined below. Incoming new students for the Fall semester must do so by July 31st and by January 5th for the Spring semester.

This is a 4-step process. Please follow the instructions for each step carefully and complete them in the following order to ensure that your records are processed without delay. ALL documentation must be in English.

Step #1: Take the Immunization Verification Form to your healthcare provider for completion. Once the form is completed, it is ready for electronic submission.

Step #2: Next, please take a photo or scan the completed form to your electronic device. Acceptable image file types are: PNG, JPG, JPED, GIF, or PDF and Txt files. It needs to be under 4 megabytes, file name with no special characters, and less than 20 characters.

Keep the original document for your own record.

Step #3: Log into Duquesne Portal and located under Student Health and Wellbeing, click to open the “Student Health Portal”. Click “Upload”, select “Duquesne Immunization Verification Form” and “Select File” to attach the document. Then select “Immunization Record” to upload a copy of the immunization record.

Step #4: Select the "Immunization" tab and scroll down to select **Required- All Students**. Please **enter the student immunization dates** in the corresponding area. Enter all the recommended immunization dates if provided, as some majors require additional immunizations.

Individuals who submit an incomplete Immunization Verification Form or who otherwise demonstrate non-adherence to immunization requirement specifications will be deemed non-compliant and unable to register for classes the following semester. Please note that both the required and recommended immunization dates need to be provided if applicable.

A physical examination is NOT required for admission to Duquesne University.

Duquesne University Health Services reserves the right to share immunization status with Duquesne University personnel on an as-needed basis.

Communication regarding non-compliance will be done via email notification from Duquesne University Health Services. If you encounter any technical issues with the online submission process, please contact us for assistance.

Phone: 412-396-1650

Email: DuHealth@duq.edu (Not a secure email -please do not include any confidential information)

Please visit the website for more information. <https://www.duq.edu/healthservices>

Thank you,

Duquesne University Health Services

DUQUESNE IMMUNIZATION VERIFICATION FORM

Last Name	First Name	Date of Birth (MM/DD/YYYY)	Duquesne ID Number
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REQUIRED VACCINES Measles, Mumps, Rubella-MMR 2 Doses of the MMR Vaccine Dose 1 <u>MUST</u> be given on or after 1st birthday. & Dose 2 given at least 4 weeks after the initial dose OR Individual vaccines of 2 doses of Measles, 2 doses of Mumps and 1 dose of Rubella OR Confirmed immunity from blood titer test (Equivocal and negative results are NOT accepted)	MMR Dose 1	O R	Measles Dose 1	Mumps Dose 1	Rubella Dose 1
	MM/DD/YYYY		Measles Dose 2	Mumps Dose 2	
	MMR Dose 2		Measles Titer	Mumps Titer	Rubella Titer
MM/DD/YYYY		MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	
OR					
Meningococcal Conjugate- MCV4					
MUST be on or after the 16th birthday. Please Circle vaccine type Menactra or Menveo	Meningococcal MCV4 MM/DD/YYYY				

<i>RECOMMENDED VACCINES</i>			
Tdap		Tdap-Due Every 10 years	
Tetanus, Diphtheria, Acellular pertussis (This is not the same as DTap)		MM/DD/YYYY	
Varicella	Varicella 1	Varicella 2	
	MM/DD/YYYY	MM/DD/YYYY	
Hepatitis A	Hep A Dose 1	Hep A Dose 2	
	MM/DD/YYYY	MM/DD/YYYY	
Hepatitis B	Hep B Dose 1	Hep B Dose 2	Hep B Dose 3
	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
HPV Human Papilloma	HPV 1	HPV 2	HPV 3
	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
Meningococcal Serogroup B	Men B 1	Men B 2	Men B 3
Please Circle vaccine type Trumenba or Bexsero	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
COVID-19	COVID-19 #1	COVID-19 #2	COVID-19 #3
Please indicate which brand. <input type="checkbox"/> Moderna <input type="checkbox"/> Pfizer <input type="checkbox"/> J&J Other- Specify below:	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY

Date	Healthcare Provider Name (Please Print)	Signature & Title	Phone Number & Address
Organizational Stamp			Please do not mail, fax, or email this form. Students need to upload this form to their Student Health account along with a copy of immunization and/or titer records.