United States Coast Guard Academy
Immunization Record Form for Class of 2026

The Notice of Privacy Practices, Military Health system effective April 14, 2003 as required by the Health Insurance Portability and Accountability Act (HIPAA) applies and can be viewed electronically at https://tricare.mil/Privacy/HIPAA.

Directions:

1. Print form; single side option. Do NOT print on both sides of the paper.
2. Use **black** ballpoint pen to complete form. Do not use felt tip pen or pencil. Line through errors, initial and provide correct information above or to the side of the applicable box. Do NOT use correction fluid/tape.
3. **Enter name and SSN on each page**
4. A physician, nurse practitioner (APRN), physician assistant (PA), nurse (RN or LPN), or other licensed provider should complete Part II. Prospective candidates are to ensure provider is aware of all directions.
5. **All immunization documentation should be written on this form.**
6. For all dates, use six digits: **month - day- year format.**
7. The form should be signed and dated **AFTER** all immunizations have been given. If an immunization is given subsequently, the provider should sign for it in the margin.
8. If serology obtained, **attach a copy of the laboratory reports.** Ensure that the value for each result and the accompanying reference scale is listed. A simple "positive" or "immune" result is not adequate.
9. Four weeks prior to reporting, fax the completed form and lab reports to CG Academy Regional Clinic at 860-701-6475. Make two copies of the form and lab reports. Keep one copy at home of record and bring second copy to the Academy. Mail the original form and lab reports to CG Academy Regional Clinic, Attn: Immunization Department, USCGA, 15 Mohegan Ave., New London, CT 06320.

Completion of this form is required to ensure the health and wellness of all at the United States Coast Guard Academy (USCGA). All specified immunizations listed are required. Prospective cadets are strongly encouraged to obtain all necessary immunizations prior to reporting because immunizations have a risk of side effects such as soreness at injection site, fatigue, headache, and fever. Receiving several of these vaccines during the first week of training may result in decreased physical performance. Additionally, it can take up to several weeks to produce an immune response sufficient to protect one from disease.

All remaining immunizations or laboratory tests will be completed at the Academy.

If you have never been immunized, or if you have questions about requesting exemptions, call a CG Academy Regional Clinic Registered Nurse at 860-701-6155. If you are unable to reach the nurse, call Medical Administration at 860-444-8430.

Part I - To be completed by the prospective cadet

"I have read and understand the above directions. I understand all immunizations specified in Part II are required for admission." Prospective cadet's signature: _____

Optional: "I authorize a CG Academy Registered Nurse to discuss my immunization record with my parent or guardian." Prospective cadet's signature: _____

Last Name

First Name

M.I. Gender Social Security Number — —

Date of Birth (mm-dd-yy) — — Email

Cell phone — —

Home phone — —

Complete all immunizations 4 weeks prior to arrival. FAX AND MAIL form.

Name _____ SSN _____

Part II - To be completed by a physician or other health care provider
Enter dates in boxes or spaces provided. Use month-day-year format (mm-dd-yy).

Tuberculosis Skin Test (TST) Information:
All appointees will be given a TST **at the Academy** unless not indicated. No TST is necessary prior to reporting.
If appointee has received BCG, enter date given: _____
If appointee has had a **positive** TST, enter date: _____ and induration _____ mm
If positive, was chest X-Ray obtained? ☐ **Yes** ☐ **No** If yes, date of X-RAY:_____
Please attach X-Ray report
Date, type and duration of prophylactic therapy, if applicable: _____
_____

Immunization history:

Hepatitis A - Two doses; at least the first dose of the series is required on entrance to USCGA
If immunization records are not available, a lab report proving immunity may be submitted instead.

#1 ☐☐ — ☐☐ — ☐☐ #2 ☐☐ — ☐☐ — ☐☐

Positive Hepatitis A antibody serology test date: _____ **Attach lab report**

Hepatitis B - Three doses; at least the first dose of the series is required on entrance to USCGA
If immunization records are not available, a lab report proving immunity may be submitted instead.

#1 ☐☐ — ☐☐ — ☐☐ #2 ☐☐ — ☐☐ — ☐☐ #3 ☐☐ — ☐☐ — ☐☐

Positive Hepatitis B surface antibody quantitative serology test date: _____ **Attach lab report**

Twinrix (Hepatitis A & Hepatitis B vaccine) may be substituted if age 18 years or older - Three doses; at least the first dose of the series is required on entrance to USCGA. Twinrix is not required if both the Hepatitis A series and Hepatitis B series have been given.

#1 ☐☐ — ☐☐ — ☐☐ #2 ☐☐ — ☐☐ — ☐☐ #3 ☐☐ — ☐☐ — ☐☐

Measles, Mumps, Rubella (MMR) - Required: two doses
If immunization records are not available, a lab report proving immunity may be submitted instead.

#1 ☐☐ — ☐☐ — ☐☐ #2 ☐☐ — ☐☐ — ☐☐
(After 1 year of age) (At least 4 weeks after first dose)

MMR IgG serology test date: _____ **Please attach lab report.** Indicate immunity status below
Rubeola (measles) ☐ immune ☐ not immune Mumps ☐ immune ☐ not immune Rubella ☐ immune ☐ not immune

Quadrivalent Meningococcal Conjugate - Required: one dose MenACWY/MCV4 (Menactra or Menveo) **after age 16 years and within 5 years of entrance to USCGA.** Enter most recent dose.
Note: Enter optional Meningococcal B (Bexsero or Trumenba) vaccinations on page 3.

Menactra ☐☐ — ☐☐ — ☐☐ **or** **Menveo** ☐☐ — ☐☐ — ☐☐

Health Care Provider's Signature _____ **Date:** _____

Health Care Provider's Name (print or use stamp) _____

Complete all immunizations 4 weeks prior to arrival. FAX AND MAIL form.

Name _____ SSN _____

Part II (continued) - To be completed by a physician or other health care provider
Enter dates in boxes or spaces provided. Use month-day-year format (mm-dd-yy).

Polio - Required: one dose **within one year of entrance to Academy.**
(One dose on accession or at/after 18 years of age required so as to be ready for world-wide travel)

☐☐ – ☐☐ – ☐☐

Please document childhood polio series:

☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐

☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐

Tetanus, Diphtheria, Pertussis - Required: one dose Tdap. If more than 10 years since administration, a subsequent dose of Td or Tdap is **also** required. List doses of Td given less than 10 years after Tdap as well.

Tdap ☐☐ – ☐☐ – ☐☐ **Td** ☐☐ – ☐☐ – ☐☐

Please document childhood DTaP series:

☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐

☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐ ☐☐ – ☐☐ – ☐☐

Varicella (Chickenpox) - Required: two doses or History of Chickenpox

#1 ☐☐ – ☐☐ – ☐☐ (After 1 year of age) #2 ☐☐ – ☐☐ – ☐☐ (At least 4 weeks after first dose)

History of Chickenpox? ☐ **YES** ☐ **NO**

Human Papillomavirus; Strongly Recommended version given: ☐ **9vHPV** ☐ **4vHPV**

#1 ☐☐ – ☐☐ – ☐☐ #2 ☐☐ – ☐☐ – ☐☐ #3 ☐☐ – ☐☐ – ☐☐

Optional: Meningococcal B version given: ☐ **Bexsero** ☐ **Trumenba**
Series cannot be completed at USCGA as neither vaccine is available at this time

#1 ☐☐ – ☐☐ – ☐☐ #2 ☐☐ – ☐☐ – ☐☐ #3 ☐☐ – ☐☐ – ☐☐

HEALTH CARE PROVIDER INFORMATION

Signature: _____ **Date:** _____

Name (print or stamp): _____

Mailing Address: _____

City, ST, ZIP: _____

Phone: _____ **Fax:** _____

Complete all immunizations 4 weeks prior to arrival. FAX AND MAIL form.

United States Coast Guard Academy

Additional Immunizations

ENTER YOUR COVID-19 VACCINATION(S) ON THIS FORM

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When you receive additional immunizations from an outside provider, please have them complete this form. Make a photocopy of the form and keep it in a safe place. Bring or mail the original form to CG Academy Regional Clinic, Attn: Immunization Department, USCGA, 15 Mohegan Ave., New London, CT 06320. If you have any questions or wish to scan/email this form, you may call a clinic Registered Nurse at: 860-701-6155 for assistance.

Use blue or black ink to print all required information clearly.

It is your responsibility to ensure that data entered by the health care provider is readable.

Name_____

Last 4 digits of Social Security Number _____

Phone _____, **E-mail address** _____

Health Care Provider: Please print the name of the vaccine and applicable information below. Use month-day-year format to record the date of administration of the specified vaccine.

Vaccine: _____, **Brand name:** _____
CVX code: _____, **Lot number:** _____
Manufacturer: _____, **Dose:** _____, **Route:** _____
Injection Site: _____, **Date administered:** _____
Date of Vaccine Information Statement (VIS): _____, **Date VIS provided:** _____
If influenza and correct CVX code unknown, indicate if pre-filled syringe, single dose vial, or multi-dose vial: _____

Vaccine: _____, **Brand name:** _____
CVX code: _____, **Lot number:** _____
Manufacturer: _____, **Dose:** _____, **Route:** _____
Injection Site: _____, **Date administered:** _____
Date of Vaccine Information Statement (VIS): _____, **Date VIS provided:** _____

Health Care Provider Information

Signature: _____ **Date:** _____

Name (print or use stamp): _____

Mailing Address: _____

Phone: _____ **Fax:** _____