Student Name: _____

Student Date of Birth: _____

IMMUNIZATIONS: *To be completed and signed by a healthcare provider.* ***All dates must include month, day, and year.***

MEASLES (RUBEOLA) – required for all programs

Persons born prior to 1957 are considered to be immune to measles.

1. Immunization with live virus vaccine:

Date 1_____Date 2 _____

(Two doses given at least 30 days apart; both doses given on or after January 1, 1968, and given on or after first birthday)

OR

2. Immunity confirmed by blood titer:

Date of test_____Result _____

(attach copy of laboratory report)

MUMPS – required for all programs

Persons born prior to 1957 are considered to be immune to mumps.

1. Immunization with live virus vaccine:

Date 1_____Date 2 _____

(Given in 1969 or later and given on or after first birthday)

OR

2. Immunity confirmed by blood titer:

Date of test_____Result _____

(attach copy of laboratory report)

RUBELLA (GERMAN MEASLES) – required for all programs

1. Immunization with live virus vaccine:

Date 1_____Date 2 _____

(Given in June 1969 or later and given on or after first birthday)

OR

2. Immunity confirmed by blood titer:

Date of test_____Result _____

(attach copy of laboratory report)

TDAP – required for all programs except MSG

Date: _____

VARICELLA (Chicken Pox) – required for all programs except CNA

1. Varicella immunization:

Date 1_____Date 2 _____

OR

2. Immunity confirmed by blood titer:

Date of test_____Result _____

(attach copy of laboratory report)

TUBERCULOSIS SCREENING – required for all programs

Initial 2-step TB test (*must be Mantoux).* After initial testing, a yearly single-step Mantoux test is required for all programs. If the student has a positive TB test, a chest x-ray must be performed, and a copy of the report attached to this record.

1. Has student ever had a positive TB skin test?

☐ No (go to #2) ☐Yes (year)_____if yes:

☐ Medication name_____

How long taken? _____

☐ Medication not prescribed

2. Has student ever had BCG vaccine?

☐ No ☐Yes (year) _____

(Persons who have received BCG vaccine are required to have a TB skin test unless they have had a previous positive reaction)

3. Chest x-ray, if necessary (attach copy of report):

Date of test_____Result _____

4. 2-step TB test: 2 Mantoux TB tests given one to three weeks apart

#1 Date Given_____Date Read_____Results_____

#2 Date Given_____Date Read_____Results _

OR

QuantiFERON test date _____

(attach copy of testing date plus copy of lab results)

OR

Three consecutive years of annual one-step TB testing:

Date Given_____Date Read_____Results_____

Date Given_____Date Read_____Results_____

Date Given_____Date Read_____Results _____

HEPATITIS B VACCINE – required for all programs except MSG

Post vaccination testing for serologic response (titer) is highly recommended.

Dose #1 Date_____

Dose #2 Date_____

Dose #3 Date _____

OR

Immunity confirmed by blood titer:

Date of test_____Result _____

(attach copy of laboratory report)

COVID-19 Immunizations – required for all programs

Dose #1 Date_____ Manufacturer _____

Lot# _____

Dose #2 Date_____ Manufacturer _____

Lot# _____

HEALTHCARE PROVIDER VERIFYING IMMUNIZATION INFORMATION

Name and Credentials (print)_____**Signature**_____**Date**_____

Address_____**Telephone** _____