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 <u>except</u> MSG

Date: _____

VARICELLA (Chicken Pox) – required for all programs <u>except</u> 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)

   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 <u>except</u> 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)

HEALTHCARE PROVIDER VERIFYING IMMUNIZATION INFORMATION

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

Address _____ **Telephone** _____