

IMMUNIZATIONS RECORD

Students provide direct client care in clinical agencies that require verification of the student's immunization / vaccination record by a health care provider.

STUDENT NAME: _____
DATE OF BIRTH: _____
STUDENT NUMBER: S _____

| IMMUNIZATIONS | DATE AND RESULTS |
|---------------|------------------|
|---------------|------------------|

- 1 VARICELLA Immunization Date: _____
OR
VARICELLA Positive Titer (blood draw) DATE: _____
Results: _____

- 2 TETANUS/DIPHTHERIA TOXOID (TD) DATE: _____
(Must be within the past 10 years)

- 3 HEPATITIS B VACCINE - 3 doses required DATE: _____
(Student may sign the Hep B waiver) DATE: _____
DATE: _____

- 4 TB INTRADERMAL (Mantoux Method) DATE: _____
(Expires in 1 year) Results: _____
OR
If **TB** skin test is positive, indicate dates DATE: _____
and results of chest x-ray (Expires in 5 years) Results: _____

- 5 MMR (Measles, Mumps & Rubella) DATE: _____
Age 18yrs or older - (1) dose is required
OR
Documented childhood MMR immunizations DATE: _____
(two doses are required) DATE: _____
OR
If date of childhood MMR is not available, DATE: _____
indicate date & results of *serologic immunity* Results: _____

- 6 Seasonal Flu Shot DATE: _____

Signature of Health Care Provider Date

Print or type name and title

Provider Address Phone

