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COMMUNITY COLLEGE OF DENVER

Health & Immunization Form
Radiologic Sciences Programs

Radiologic Science students at participate in clinical education in a variety of healthcare facilities. The program clinical affiliates require that staff and students be free from communicable diseases.

The Joint Review Committee on Education in Radiologic Technology requests the college maintain a Health Record for each student. This medical health form must be completed by a physician or authorized healthcare provider. Please complete every item on this form as carefully as possible.

Note—all immunizations are to be current; the TB skin test must be updated each year.

PHYSICAL EXAMINATION FOR: ____

PHYSICIAN'S DECLARATION:
I hereby certify that I have personally examined the individual named on this report.

IMMUNIZATION/VACCINATION	**Dates and Results**
VARICELLA (*Chicken Pox*):	Immunization date: **OR** Positive Titer Date:
Has this person had chicken pox?	☐**YES** ☐ **NO**
TETANUS/DIPTHERIA TOXOID (TD) *Note: Must be within past 10 years*	Date:
HEPATITIS B VACCINE—3 doses required	Date dose 1: Date dose 2: Date dose 3: Or Positive Titer Date:
TB INTRADERMAL (Mantoux Method) *Note: Must be within past 3 months*	Date: Results:
If TB skin test is positive, indicate dates & results of Chest x-ray	Date: Results:
MMR-Two (2) doses required *Note: not required if born BEFORE 1957*	Date dose 1: Date dose 2:
If dates of MMR not available, indicate date and results of serologic immunity	Date: Results:
Annual Flu Shot (seasonal)	
Respirator Fit Test Date & Mask Size ****Will be completed on campus**	

Signature of Healthcare Provider: ______________________ Date: ______________

Name (please print): ____

Title: ______________________________ Phone#: ______________

Provider's Address: ____