Center for Health Sciences
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COMMUNITY COLLEGE OF DENVER

HEALTH & IMMUNIZATION FORM

First Name: ________________________ Last Name: ________________________

SID#: S___________________________ Phone: ____________________________

Email: ____@student.cccs.edu

Note: Your official CCD email account is the only email CCD will accept for correspondence.

Student Signature: ________________________________ Date: ______________

Return to: Lorraine Yost **Date Received/Initials:** ___/____/____ / ________

Radiologic Science students 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 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: ____

I hereby certify that I have personally examined the individual named on this report.

PHYSICIAN'S DECLARATION: ____

IMMUNIZATION/VACCINATION

VARICELLA (Chicken Pox):

Immunization date: ___/____/____ Positive Titer date: ___/____/____

Has this person had chicken pox? ☐ Yes ☐ No

TETANUS/DIPTHERIA TOXOID (TD):

Date: ____/____/____ ***Note: Must be within past 10 years**

HEPATITIS B VACCINE – 3 doses required:

Date Dose 1: ___/____/____ Date Dose 2: ___/____/____

Date Dose 3: ___/____/____ Positive Titer date: ___/____/____

HEALTH AND IMMUNIZATION FORM

TB INTRADERMAL (Mantoux Method):

Date: _____/_____/_____ Results: ____

***Note Must be within last 3 months**

If TB skin test is positive, indicate dates & results of Chest X-Ray

Date: _____/_____/_____ Results: ____

MMR- Two (2) doses required:

Date dose 1: ____/_____/_____ Date dose 2: ____/_____/_____

***Note: Not required if born BEFORE 1957**

If dates of MMR are not available, indicate date and results of serologic immunity

Date: _____/_____/_____ Results: ____

Annual Flu Shot (seasonal):

Date: _____/_____/_____

Respirator Fit Test:

Date: _____/_____/_____ Mask Size: ______________________

***Will be completed on campus

Signature of Healthcare Provider: _____________________________ Date: ____/_____/_____

Name (print): ____

Title: _______________________________________ Phone #:_____________________________

Provider's Address: ____