HEALTHCARE STUDENT IMMUNIZATION FORM

Section A: Student & Course Info

STUDENT NAME: ***(Please Print)*** _____ **Last Name** **First Name** **Middle Initial**	**EMAIL:**_____ **PHONE NUMBER** _____ **(Area Code)** **Phone Number**
_____ **Street Address** **City** **State** **Zip**	
COURSE NAME/#: HLC 120 **SEMESTER/YEAR:** SUMMER 2017 **SECTION NUMBER:** **INSTRUCTOR NAME: Tammy Alander**	

Section B: Tests & Immunizations

Tests/Immunizations	Dates	Needed When Dates Unknown
MMR (Measles / Mumps / Rubella) Must provide documentation of 2 MMR vaccinations	**#1 MMR Date:**_____ **#2 MMR Date:**_____ Must have 2 if born after 1957. **If no MMR documentation,** **Must provide Positive Titer Results**	**MMR Titer Date if Immunization Date Unknown:**
Varicella (Chicken Pox): Must provide documentation of 2 doses of Varicella vaccine	**#1 Varicella Date:**_____ **#2 Varicella Date:**_____	**Titer date proving immunity if immunization date unknown:**
TB Skin Test (PPD) **Must have 2 within the last 12 months. Second PPD can be placed one week after 1st PPD placed.** If positive, must have an initial chest X-ray then complete symptoms review annually.	**#1 PPD Date & Results :**_____ **#2 PPD Date & Results :**_____	
Chest X-ray Required if TB skin test is positive. Negative X-ray requires annual symptoms review.	**X-ray Date & Result:**_____	**Symptom Review Questionnaire Required Annually** **Date Completed:**
Hepatitis B Requires positive Hep B titer or series of 3 doses. **Titer Date / Results:**_____	**If negative titer** **#1 Hep B Date:**_____ **#2 Hep B Date:**_____ **#3 Hep B Date:**_____	**If vaccine declined, note date declination form signed:** _____
Tdap Required once as an adult.	**Date:**	

I attest to the accuracy of the above medical information and, if requested, documentation of same will be provided on request.

Date: _____Verified by: _____, (Signature of Healthcare Provider or School Nurse)

Name and Title PRINTED: _____