

## 911 PROGRAMS Immunization Form

Student Name \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Course ID# \_\_\_\_\_

ATTENTION STUDENTS: This form must be filled out **in its entirety** to be eligible for clinical rotations. No exceptions. Unsigned forms **MUST** be accompanied by supportive documentation.  
 ATTENTION CLINICIANS: Please see the parameters for each immunization. They are required for the student to enter clinical internship.

**PLEASE WRITE LEGIBLY TO RECEIVE CREDIT**

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| <p><b>Tuberculin Sensitivity Test (aka the Mantoux Test, Pirquet Test, or PPD)</b></p> <p>2-step PPD test is required. The first plant must be within last 365days<br/>                 Readings must occur within 48-72 hours.</p> <p>Second Plant Must be within 6 months of intended clinical</p> <p>Date of 1<sup>st</sup> plant: ____ / ____ / ____</p> <p>Date of reading: ____ / ____ / ____ Result ____ mm</p> <p>Date of 2<sup>nd</sup> plant: ____ / ____ / ____</p> <p>Date of reading: ____ / ____ / ____ Result ____ mm</p> <p>For healthcare workers, a reading of &gt;10mm constitutes a positive result.<br/>                 Positive PPDs require a chest X-ray and the following must be documented:</p> <p>Positive PPD date: ____ / ____ / ____ Result ____ mm</p> <p>Chest X-ray date*: ____ / ____ / ____ Result ____ mm<br/> <i>*Chest X-ray must be on or after the positive ppd date</i></p> <p>Quantum Gold: Date: ____/____/____ Result: _____</p> | <p><b>Measles, Mumps, and Rubella (MMR)</b></p> <p>Students born on or after January 01, 1957 require 2 measles, 2 mumps, and 1 rubella vaccinations or a positive titer for each</p> <p>Students born on or before December 31, 1956 require 1 measles, 1 mumps, and 1 rubella or a positive titer for each</p> <p><b>Measles (Rubeola) Vaccine</b></p> <p>#1: ____ / ____ / ____ #2: ____ / ____ / ____</p> <p><b>OR</b></p> <p>Titer date: ____ / ____ / ____ Result: _____</p> <p><b>Mumps Vaccine</b></p> <p>#1: ____ / ____ / ____ #2: ____ / ____ / ____</p> <p><b>OR</b></p> <p>Titer date: ____ / ____ / ____ Result: _____</p> <p><b>Rubella (German Measles) Vaccine</b></p> <p>#1: ____ / ____ / ____</p> <p><b>OR</b></p> <p>Titer date: ____ / ____ / ____ Result: _____</p> <p><b>MMR Vaccine (if done as one instead of individually)</b></p> <p>#1: ____ / ____ / ____ #2: ____ / ____ / ____</p> |
| <p><b>Varicella (Chicken Pox):</b></p> <p>Healthcare Provider Dx of Varicella Disease:      Date ____ / ____ / ____</p> <p><b>OR</b> Varicella Vaccine: #1 ____ / ____ / ____ and #2 ____ / ____ / ____</p> <p><b>OR</b> Titer:      Date: ____ / ____ / ____      Result _____</p>  | <p><b>Tetanus, Diphtheria, Pertussis (Tdap) If Td older than 2 years</b></p> <p>Tdap: ____ / ____ / ____      Td: ____ / ____ / ____</p> <hr/> <p><b>Hepatitis B (optional except if exposed to blood or body fluids)</b></p> <p>#1: ____ / ____ / ____ #2: ____ / ____ / ____</p> <p>#3: ____ / ____ / ____ Or signed declination: YES NO</p> <p>Or Titer (HbsAB): ____ / ____ / ____ Result: _____</p>   |
| <p><b>Provider Information (filled out by authorizing health care provider)</b></p> <p>Name: _____</p> <p>Signature: _____</p> <p>Phone #: _____</p>   | <p><b>Seasonal Influenza (MANDATORY)</b></p> <p>Date: ____ / ____ / ____</p>   |