911PROGRAMS 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

Tuberculin Sensitivity Test (aka the Mantoux Test, Pirquet Test, or PPD)

2-step PPD test is required. The first plant must be within last 365days
Readings must occur within 48-72 hours.

Second Plant Must be within 6 months of intended clinical

Date of 1st plant: _____ / _____ / _____

Date of reading: _____ / _____ / _____ Result _____ mm

Date of 2nd plant: _____ / _____ / _____

Date of reading: _____ / _____ / _____ Result _____ mm

For healthcare workers, a reading of >10mm constitutes a positive result.
Positive PPDs require a chest X-ray and the following must be documented:

Positive PPD date: _____ / _____ / _____ Result _____ mm

Chest X-ray date*: _____ / _____ / _____ Result _____ mm
Chest X-ray must be on or after the positive ppd date

Measles, Mumps, and Rubella (MMR)
Students born on or after January 01, 1957 require 2 measles, 2 mumps, and 1 rubella vaccinations or a positive titer for each

Students born on or before December 31, 1956 require 1 measles, 1 mumps, and 1 rubella or a positive titer for each

Measles (Rubeola) Vaccine

#1: _____ / _____ / _____ #2: _____ / _____ / _____
OR
Titer date: _____ / _____ / _____ Result: _____
Mumps Vaccine

#1: _____ / _____ / _____ #2: _____ / _____ / _____
OR
Titer date: _____ / _____ / _____ Result: _____
Rubella (German Measles) Vaccine

#1: _____ / _____ / _____
OR
Titer date: _____ / _____ / _____ Result: _____
MMR Vaccine (if done as one instead of individually)

#1: _____ / _____ / _____ #2: _____ / _____ / _____

Varicella (Chicken Pox):
Healthcare Provider Dx of Varicella Disease: Date____/____/____

OR Varicella Vaccine: #1 ____/____/____ and #2 ____/____/____

OR Titer: Date: ____/____/____ Result_____

Tetanus, Diphtheria, Pertussis (Tdap) w/in 10 years or Td w/in 2 years

Tdap: _____ / _____ / _____ Td: _____ / _____ / _____

Hepatitis B (optional except if exposed to blood or body fluids)
#1: _____ / _____ / _____ #2: _____ / _____ / _____
#3: _____ / _____ / _____ Or signed declination: YES NO
Or Titer (HbsAB): _____ / _____ / _____ Result: _____

Provider Information (filled out by authorizing health care provider)

Name:_____

Signature: _____

Phone #: _____

Seasonal Influenza (MANDATORY)

Date: _____ / _____ / _____