

Student Immunization Checklist



Name: _____ SS# or Student ID: _____ Date of Birth: _____
Last First Middle/Maiden MM/DD/YYYY

Required Immunization--Must be completed by MD/PA/NP/RN/Health Dept. Representative

Measles Vaccine or MMR	OR	Measles Antibody Titer
Date 1: _____ / _____ / _____ Date 2: _____ / _____ / _____		Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive (Immune Status) <input type="checkbox"/> Negative

Mumps Vaccine (or MMR recorded above)	OR	Mumps Antibody Titer
Date 1: _____ / _____ / _____ Date 2: _____ / _____ / _____		Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive (Immune Status) <input type="checkbox"/> Negative

Rubella Vaccine (or MMR recorded above)	OR	Rubella Antibody Titer
Date 1: _____ / _____ / _____ Date 2: _____ / _____ / _____		Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive (Immune Status) <input type="checkbox"/> Negative

Varicella Vaccine	OR	Varicella Antibody
Date 1: _____ / _____ / _____ Date 2: _____ / _____ / _____		Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive (Immune Status) <input type="checkbox"/> Negative

Tetanus		
Td	OR	Tdap
Date: _____ / _____ / _____ (required every 10 years)		Date: _____ / _____ / _____ (required every 10 years)

TB Skin Test (TST)	
Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm Induration Date: _____ / _____ / _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative _____ mm Induration	If positive, CXR date and result: _____ Treatment: _____

Hepatitis B	
Vaccine	OR
Date 1: _____ / _____ / _____ Date 2: _____ / _____ / _____ Date 3: _____ / _____ / _____	Hep B Antibody Date 1: _____ / _____ / _____ Results: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

Seasonal Flu (upon availability)
Date: _____ / _____ / _____

_____ () _____
Health Care Provider Signature/Stamp Date Telephone Number

SECTION B: Personal Health History – To be completed by the applicant

Do you have any disease/condition/injury for which you are being treated or periodically evaluated? Yes No

If yes, please explain: _____

Are you taking any medication(s) on a regular basis? Yes No

If yes, please list all medication(s) and dosage: _____

Have you had or are you being treated for psychiatric or emotional conditions? Yes No

If yes, please explain: _____

Do you have any allergies: Yes No

If yes, please list:
 Drug _____
 Food _____
 Other _____

If you answered **YES** to any of the above questions, a statement from your physician may be required.

I, _____, submit this Personal Health History as being accurate and complete. I understand that falsification or inaccurate information may result in dismissal from the program.

 Applicant Date () Telephone Number

Student Additional Information:

Measles, Mumps, Rubella (MMR) – Must provide:

- Documentation of 2 measles vaccines, 2 mumps vaccines and 2 rubella vaccine after 1st birthday **OR**
- Documentation of positive antibody (immunity) to measles, mumps, and rubella **OR**
- If no documentation, 2 measles vaccines, 2 mumps vaccines and 2 rubella vaccines are required
- Note: If titer is equivocal, student must receive vaccine. (*History of disease, even from a physician, is not acceptable*).

Varicella (Chicken Pox) – Must provide:

- Documentation of 2 varicella vaccines **OR**
- Documentation of varicella positive antibody (immunity)
- Note: If titer is equivocal, student must receive vaccine. (*History of disease, even from a physician, is not acceptable*).

Tetanus, Diphtheria, Pertussis – Must provide:

- Documentation of a Td or Tdap that is current within 10 years.
- Individuals should receive booster every 10 years.

TB Skin Test (TST) – Must provide:

- Documentation of receiving a TB skin test in the past 12 months. Only 1 additional skin test is required. **OR**
- Documentation of 2 step TST is required:
Step One: First test to be administered and results to be read within 48-72 hours. If positive, TB questionnaire and clear chest X-ray required from healthcare provider. If result is negative, proceed to Step Two.
Step Two: Second test to be administered in 1 to 3 weeks after first test and be read within 48-72 hours. If second test is positive, TB questionnaire and chest X-ray required from healthcare provider.