Immunization/Serology Records

A. EVIDENCE OF TB SCREENING COMPLETED 6 MONTHS PRIOR TO START DATE:

Date Received:_________________________________________________________
Result (Indicate mm of In duration):____________________________________ mm
Physician/Registered Nurse Signature:____________________________________
License #:____________________________________________________________

NOTE: If your PPD is currently positive (>10 mm) or you have a previous history, you must submit a recent chest X-ray with a signed physician report within 11 months of start date. Student with a history of BCG vaccination or anti-tuberculosis therapy are not excluded from this requirement.

B. MANDATORY REQUIREMENTS:

1. Tetanus/Diphtheria (Tdap) booster within the last 10 years:

Booster date:__________________________________________________________

2. Measles, Mumps, Rubella, Varicella within the last 10 years:

All students must submit copies of laboratory results of serum IgG antibody titers to measles, mumps, rubella (MMR), and varicella. Immunization records are NOT accepted as proof of immunity. Any laboratory results that indicate non-immunity require proof of additional vaccine administration.

Measles titer date/results:______________________________________________
Mumps titer date/results:_______________________________________________
Rubella titer date/results:_______________________________________________
Varicella titer date/results:_____________________________________________
3. Hepatitis B Series within the last 5 years:

Documentation of three doses of hepatitis B vaccine, and a positive hepatitis B surface antibody titer is necessary. Copy of laboratory results must be submitted.

Series #1 Date: ________ #2 Date: ________ #3 Date: ________

Hepatitis B Surface Antibody titer date/results: __________________________

Negative Hepatitis B Surface Antibody titer requires additional titers

Hepatitis B Core Antibody titer date/results: __________________________

Hepatitis B Surface Antibody titer date/results: __________________________

Hepatitis B e antigen titer date/results: __________________________

(Note: non-converters should repeat the series in an attempt to show immunity)

Known Hepatitis B carriers must show copies of the following laboratory results:

Hepatitis B Surface Antibody
Hepatitis B Surface Antigen
Hepatitis B Core Antibody
Hepatitis B e Antigen

4. Influenza vaccine (within 1 year)

Date received: __________________________

I have been asked to evaluate and certify that the student is free from any health impairment which is of potential risk to patients or may interfere with the performance of his/her duties. This includes habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances that may alter the individual's behavior.

Physician Signature __________________________ Date __________________________

Physician Name (Print) __________________________ Country/State License _________________

Address: City: __________________________ State/Country: __________________________ Zip Code: _________________