RECORD OF IMMUNIZATIONS

NOTE: Please provide dates for each requested blank unless otherwise specified.

TETANUS/DIPHTHERIA: Toxoid (______)  (______)  (______)
Booster: (______)  (Tetanus Booster must be within 8-10 years. See specific program requirements.)

MEASLES/MUMPS/RUBELLA:
If born before 01/01/57, either:

Proof of immunity to Rubella by Rubella titer: Immune Status/Date: (__________)
OR
M/M/R Vaccine (Date of injection): (__________)  (retiter not necessary)

If born after 1/1/57, two doses of MMR are required:
   Dose number 1 __________________
       (Immunization received as infant may be used as first dose.)
   Dose number 2 __________________

2 Step PPD TB Test: Note TINE TESTS ARE NOT ACCEPTABLE

Date of “first step” test: (NOTE: must be within one year of current test) __________________
   Reaction: ___ mm induration

Date of current test: (Note: must be within one month of start of academic year) __________
   Reaction: ___ mm induration

   If candidate has a positive PPD, has he/she been evaluated for/received INH chemoprophylaxis ________

   If old positive PPD, date of chest x-ray within 6 months of admission date: __________

HEPATITIS B SERIES:

   Date of First Dose: ______________
   Date of Second Dose (One (1) month after 1st dose): ______________
   Date of Third Dose (Six (6) months after 1st dose): ______________

   OR

   Serologic confirmation of immunity to hepatitis B virus: Date: ______________
       Immune Status: ______________

VARICELLA:

   Date of 1st dose: ______________
   Date of 2nd dose: ______________

   (Required if 1st dose was given after 13 years of age.)

   OR

   Serologic confirmation of immunity to varicella virus: Date: ______________
       Immune Status: ______________