Name: _____ Program: _____ Date: _____

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:_____