Immunization Record (To be completed by a physician or primary healthcare provider.)

Name _____
Last *First* *Middle* *Former name, if applicable*

Today's Date _____ Birth Date _____ Social Security Number _____

All information must be in English. A copy of original immunization record(s) is/are preferred.
Please attach lab reports or numerical results for all positive antibodies

Tetanus-Diphtheria Booster must be within the last ten years. One dose of Tdap is required.
____/____/____ Expires 10 years from date of injection

MMR (Measles, Mumps, Rubella) Either has a report of a positive immune titer for Measles, mumps and Rubella or two doses is required for all students born on or after 01/01/1957.
_____/_____/_____ □ Positive Titer for (each) MMR
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2

Hepatitis B Three doses of vaccine, reactive Hepatitis B surface antibody lab results, or signed Hepatitis vaccination waiver form is required for all students.
_____/_____/_____ □ Reactive Hepatitis B Surface Antibody
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2
_____/_____/_____ □ Dose 3
_____/_____/_____ □ Hepatitis waiver

Chicken Pox (Varicella) History of chicken pox, lab report of positive varicella antibody, or two doses of vaccine
_____/_____/_____ □ History of chicken pox
_____/_____/_____ □ Reactive Varicella Antibody
_____/_____/_____ □ Dose 1
_____/_____/_____ □ Dose 2

Two-Step Tuberculosis Screening Skin test (PPD) required regardless of prior BCG inoculation. A skin test expires annually and chest x-rays expire after five years. May be substituted for Interferon Gamma Release Assay.

- **Skin Test**

If skin test is positive, a Chest x-ray must be documented below.
_____/_____/_____ □ Date Given
_____/_____/_____ □ Date Read
_____ Result in mm (if no induration, write '0')

_____/_____/_____ □ Date Given
_____/_____/_____ □ Date Read
_____ Result in mm (if no induration, write '0')

- **Chest X-Ray** (required if PPD skin test is positive):

_____/_____/_____ □ Date of chest x-ray □ Normal □ Abnormal

Influenza *Annual* seasonal Flu Vaccine is required for admission to Clinicals.
_____/_____/_____ □ Date Given/Dose 1

Medical Exemption The student named above does not have one or more of the required immunizations because she/he has a medical problem that precludes the vaccine(s).
_____
_____
_____
_____

Recommended Alternative:
_____
_____

_____
Physician's/Care Provider's Signature

_____
Date

Conscientious Exemption:
I hereby certify by notarization the immunization against _____
is contrary to my conscientiously held beliefs and I understand not receiving all required vaccinations may prevent acceptance into the program.
Subscribed and sworn before me on the _____ day of _____, 20 _____.

_____
Signature of Notary

_____
Date

Notary Stamp Required For Conscientious Exemptions Here