Medical Professionals: Please read requirements thoroughly.

Immunizations and Tests Required by State Law/Clinical Facilities

Name: _____ **Date of Birth:** _____

Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 28 days apart.

ALL DATES MUST INCLUDE MONTH, DAY AND YEAR.

Measles (Rubeola), Mumps & Rubella (MMR)	**A.** **Two** doses of Measles, Mumps, Rubella (MMR) vaccine on or after their first birthday and at least 28 days apart **OR**	Date #1:_____/_____/_____ Date #2:_____/_____/_____
	B. Serologic test positive (1.1 AI or greater) for Measles IgG antibody	Date of Collection:_____/_____/_____ ____Positive ____Negative
	B. Serologic test positive (1.1 AI or greater) for Mumps IgG antibody	Date of Collection:_____/_____/_____ ____Positive ____Negative
	B. Serologic test positive (10 IU/mL or greater) for Rubella IgG antibody	Date of Collection:_____/_____/_____ ____Positive ____Negative
Varicella	**A.** **Two** doses of Varicella vaccine on or after their first birthday and at least 28 days apart. (Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13)). **OR**	Date #1:_____/_____/_____ Date #2:_____/_____/_____
	B. Serologic test positive (1.10 ISR or greater) for Varicella IgM antibody **OR**	Date of Collection:_____/_____/_____ ____Positive ____Negative
	C. Physician documented history of Varicella (Chicken Pox)	Disease Date:_____/_____/_____
Hepatitis B - doses required	**A.** Dose 1 (initial dose)	Date #1:_____/_____/_____
	A. Dose 2 (minimum 4 weeks after date #1) ****If adult 2-dose Dynavax (Hepsilav-B) or PreHevBrio, 3rd dose is not required**	Date #2:_____/_____/_____
	A. Dose 3 (minimum 8 weeks after date #2 *and* minimum 16 weeks after date #1) **OR**	Date #3:_____/_____/_____
	B. Serologic test positive (11.5 mIU/mL or greater)for Hepatitis B antibody	Date of Collection:_____/_____/_____ ____Positive ____Negative
Tdap	**A.** Must be current within the last 10 years.	Date:_____/_____/_____
TB	**A.** TB 2-step TST or by QuantiFERON-TB Gold blood assay must be completed within 180 days before the class start date.	Result Date: _____/_____/_____ ____Positive ____Negative
TB+	**B.** If positive TB result is found, a clear chest X- Ray must be presented before the class start date.	Result Date: _____/_____/_____
Flu	**A.** Current seasonal flu vaccine for clinical rotations. Must be maintained each season/year	Date:_____/_____/_____ LOT:_____

Physician or Approved Licensed Health Professional Information: Date of signature below must be after last immunization or additional immunization forms must be signed and dated separately.

Provider's Printed Name:	STAMP HERE:
Clinic Address:	
Provider's Signature:	Date:_____/_____/_____