**Student name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DOB**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

To be completed by your Healthcare Provider – **ALL LAB REPORTS MUST BE ATTACHED**

**Immunization & Titer Information** **\*\* (Titers are required where indicated)**

**1. MMR vaccine #1 \_\_\_\_\_\_\_\_\_\_\_\_\_ MMR vaccine #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_ OR**

Measles (Rubeola) IgG date: \_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_ if negative 2 MMRs are required #1\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_

Mumps IgG titer date: \_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_ if negative 2 MMRs are required #1\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_

Rubella IgG titer date: \_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_ if negative 1 MMRs is required #1\_\_\_\_\_\_\_\_\_\_

**2. HEP B #1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ # 3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** **OR**

\*\***Hep B surface antibody IgG titer** (not an antigen test) **date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*if negative* Hep B #1 Booster date**:** \_\_\_\_\_\_\_\_\_\_\_\_\_ titer after 1 month date: \_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_

*if negative* Hep B #2\_\_\_\_\_\_\_\_\_\_\_\_\_ Hep B #3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ titer date: \_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Varicella** **vaccine** #1 \_\_\_\_\_\_\_\_\_\_\_\_ #2 \_\_\_\_\_\_\_\_\_\_ **OR** titer date: \_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Flu Vaccine for all students that ARE NOT 100% remote: \_\_\_/\_\_\_/\_\_\_**

**5. COVID VACCINE** -

Moderna #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2\_\_\_\_/\_\_\_\_/\_\_\_\_

Pfizer #1 \_\_\_\_/\_\_\_\_/\_\_\_\_ #2\_\_\_\_/\_\_\_\_/\_\_\_\_

Johnson & Johnson (Janssen) #1\_\_\_\_/\_\_\_\_/\_\_\_\_

Booster #1\_\_\_\_/\_\_\_\_/\_\_\_\_

**Other Immunizations Required**

**6. Tdap** w/in the last 10 years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(Td does not fulfill this requirement)**

**7. Meningitis vaccine (ACWY)** w/in the last 5 years \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR**

**Men B series** #1 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ #2 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **OR**

**Sign** the attached meningitis waiver

**TB screening - must be within the last 12 months**

**8. PPD complete all blanks**

Date placed \_\_\_\_\_\_\_\_\_\_ Date read \_\_\_\_\_\_\_\_\_\_\_ mm of induration \_\_\_\_\_\_\_ Interpretation: Neg or Pos

Manufacturer\_\_\_\_\_\_\_\_\_\_\_\_\_ lot \_\_\_\_\_\_\_\_\_\_\_exp. date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*If positive* – must supply a negative quantiferon gold or T-spot

**OR**

**Quantiferon Gold or T-spot**  date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Chest X-ray – required for positive Quantiferon Gold or T-spot**  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_ results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Treatment for positive TB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ name of medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date started: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (include documentation)

PHYSICIAN OR HEALTH CARE PROVIDER (Must be signed & dated to be acceptable)

Printed Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_