IMMUNIZATION VERIFICATION RECORD

STUDENT MUST ALSO SUBMIT A COPY OF IMMUNIZATIONS

PART 1 – TO BE COMPLETED BY THE **STUDENT**

Name: _____

Last First Middle I.

Date of Birth: _____SS# _____Phone_____

Month/Day/Year

Address: _____

Street P O Box City ST Zip Code

Date of Enrollment at OLC: _____

PART 2 – TO BE COMPLETED AND SIGNED BY A **HEALTH CARE PROVIDER**

Dates must include month and year-**Required by all students**

Hepatitis B Vaccine:

Date Began: _____ Date of 2nd injection: _____Date complete: _____

The student should have received the **first two of the series** by the time classes start.

Serologic evidence of positive titer (anti-HBs) indicating immunity

Spedify Date and test results: _____/_____

Month Year

Tuberculosis-Check appropriate box

1. _____PPD test within the past year (Tine or Mantoux not acceptable)
   Give Date and test results: _____/_____
   Month Year
2. _____Positive PPD-Chest x-ray required. Give date & result of chest x-ray:
   _____/_____
   Month Year
3. _____Had BCG vaccine-Chest x-ray required if PPD not done, with results:
   _____
   Month Year
4. _____Quantiferon -TB Gold
   Give Date and test results: _____/_____
   Month Year

MMR-Check appropriate box (Measles, Mumps and Rubella): 2 doses, 4 weeks apart **AND** titer

1. _____ Serologic evidence of immune titer. Specify date of titer_____/_____

   Month Year

2. _____Immunized with vaccine at 12 months of age (or later) _____/_____ **AND**

   Month Year

3. _____Second Immunization (usually at 4-6 years) _____/_____

   Month Year

4. _____Had disease; confirmed by office record_____/_____

   Month Year

TdaP –Check appropriate box (Tetanus, Diphtheria, and Pertussis)

1. Completed primary series of TdaP immunization_____/_____

   Month/ Year

2. Received tetanus-diphtheria booster within last ten years_____

   Month Year

Varicella-(Chicken Pox): 2 doses, 4 weeks apart **AND** titer

1. _____Immunized with varicella immunization at 12 months of age (or later) _____/_____ and

   Month/ Year

2. Second immunization (usually at 4-6 years) _____/_____ **OR**

   Month/ Year

3. _____Had disease; confirmed by office record_____/_____

   Month Year

4. _____ Serologic evidence of immune titer. Specify date of titer_____/_____

   Month Year

Influenza- (Flu): 1 dose annually, unless contraindication (must specify)

1. _____Immunized with influenza immunization _____/_____

   Month Year

2. _____Contraindicated, confirmed by Health Care Provider.

   Reason_____

Health Care Provider

Name_____

Address_____

Signature_____

Phone_____

Revised 9-2018