TB SCREENING AND IMMUNIZATION RECORD

To Be Completed By Physician OR Health Department. Please include a TB SCREENING consisting of date given/placed & result with date.

Immunizations | Date

Tetanus-Diptheria (TD, DTaP, DTP, or Tdap) BOOSTER **REQUIRED** ______________

(Must be within 10 years)

Measles/Mumps/Rubella (given @ 12months or later) **REQUIRED** ______________

Measles/Mumps/Rubella BOOSTER (given at least 28 days after 1st dose) **REQUIRED** ** ______________

Meningitis Vaccine (receive vaccine or sign waiver pg 4) **REQUIRED** ______________

Chicken Pox disease Yes No Date _________ Vaccine (**Recommended**) **#1**______________ #2_____________

Hepatitis B: (**Recommended**) #1 ____________ #2 __________#3 _____________

Hepatitis A (**Recommended**) #1__________ #2__________

POLIO (last booster date) ______________

** MMR booster not required if birth-date is before 1956

TB SCREENING REQUIRED – Not part of standard immunization record.
Must be complete prior to registering for classes.

TB Skin Test: PPD (WITHIN PAST YEAR) * * * **REQUIRED** ***

Date Given : ______________ **PPD RESULT:** ________**mm** **Date Read:** ______________

X____

SIGNATURE OF PHYSICIAN / HEALTH DEPARTMENT OFFICIAL DATE

____

STREET ADDRESS STATE ZIP

____

OFFICE PHONE NUMBER