DOCUMENTATION OF IMMUNIZATION FORM

Student: Please have your Health Care Provider complete this form and the enclosed medical release form and **return to:**
College of Health Professions, University of Detroit Mercy, 4001 W McNichols, Detroit, MI 48221-3038
Graduate Nursing and Nurse Anesthesia – Attn: Suzanne Erwin erwinsm@udmercy.edu 313 993-1923
DNP and Physician Assistant – Attn: Rahima Ahmed ahmedra@udmercy.edu 313 578-0438
Nursing (Graduate and Undergraduate), Health Systems Management, Health Information Management – Attn: Cheryl Walker walkercv@udmercy.edu 313 993-1670
All requested information must be completed. If information is not returned by the due date assigned by your program, you will not be able to attend clinical and progression may be halted.

HEALTH CARE PROVIDER: Please complete and sign forms. Keep actual lab results on file in your office. Return only this sheet and Health Care Record Form to the address above.

Student Name: _____
Last First Middle

T. B. Status:
PPD Result: _____ Date Read: _____ (required annually)
OR
Chest X-Ray: Result: _____ Date Taken: _____ (required every 3 years)

SUMMARY OF IMMUNIZATIONS STATUS

Disease	Titer: Date & Results (+/-)	Immunization: Date	History of Disease
Mumps			
Rubella			
Rubeola (Measles)			
Hepatitis B Virus		1. 2. 3.	
Tetanus, Diptheria, and Pertussis (Tdap)	NA		
Seasonal flu vaccine			
Varicella			
Latex Allergy	**YES**	**NO**	

I have examined this student and find him/her to be free of communicable disease and able to participate in a clinical education program.

YES ____ NO _____ YES with these accommodations _____

_____

HEALTH CARE PROVIDER:

(Signature) X _____ Date: _____

Name (Printed) _____ Title: _____

Office Address: _____ Phone: _____