UNIVERSITY OF
DETROIT MERCY
COLLEGE OF HEALTH PROFESSIONS & MCAULEY SCHOOL OF NURSING

DOCUMENTATION OF IMMUNIZATION FORM

Please have your Health Care Provider complete this form. Positive titer AND/OR immunization dates required. **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.

Student Name: _____
Last First Middle

T. B. STATUS:

PPD/Blood Test 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, Diphtheria, and Pertussis (Tdap)	NA		
Seasonal Flu Vaccine			
Varicella			
COVID-19 Vaccine			
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: _____ Date: _____

Name (Printed): _____ Title: _____

Office Address: _____ Phone: _____

Completed forms are uploaded per instructions below:
Nursing (Graduate and Undergraduate) – ACEMAPP; Nurse Anesthesia – Typhon; Physician Assistant - ACEMAPP and Typhon; Health Services Administration – Attn: Vickie Winters winterva1@udmercy.edu