

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

Nursing (Graduate and Undergraduate) – upload to your ACEMAPP account

Nurse Anesthesia – upload to your Typhon account

Physician Assistant – upload to your ACEMAPP and Typhon account

Health Services Administration – Attn: Munai Newash newashmt@udmercy.edu 313-993-1146

DNP – Attn: Rahima Ahmed ahmedra@udmercy.edu 313-578-0438

Health Information Management – Attn: Paula Strussione-Sumner pstrussi@udmercy.edu 313-578-0569

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, Diphtheria, 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: _____