



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 are required. **All requested information must be completed.** If the required information is not submitted by the due date assigned by your program, you will not be permitted to attend clinical, and program progression may be delayed.

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: _____

THIS FORM MUST BE COMPLETED, SIGNED, AND UPLOAD TO YOUR ACEMAPP ACCOUNT.