DOCUMENTATION OF IMMUNIZATION FORM

Please have your <u>Health Care Provider complete this form</u>. 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	First Mi		ddle	
T. B. STATUS):					
		Date Read:	(required annually)		ually)	
or						
Chest X-Ray	Result:	Date Taken:	(required every 3 years)			
	SUI	MMARY OF IMMUNIZ	ATIONS S	STATUS		
Disease		Titer: Date & Results (+/-)	Immuniz	zation: Date	History of Disease	
Mumps						
Rubella						
Rubeola (Measles)						
Hepatitis B Virus			1. 2.	1. 2. 3.		
Tetanus, Diphtheria, and						
Pertussis (Tdap)		NA				
Seasonal Flu Vaccine						
Varicella						
COVID-19 Vacc	ine					
Latex Allergy		YES		NO		
education program.		nd him/her to be free of communith these accommodations:		_		
HEALTH CARE P						
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 winterval@udmercy.edu