DOCUMENTATION OF IMMUNIZATION FORM

Student: Please have your Health Care Provider complete this form. Students should submit form using instructions below.

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
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.

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: ____________________