

**COLUMBUS TECHNICAL COLLEGE
THE SCHOOL OF HEALTH SCIENCES
IMMUNIZATION FORM**

Name: _____ SS or Student ID# _____

Address: _____ City: _____ State: _____

Zip: _____ Phone: (____) _____ Email: _____

Birth Date: ____/____/____ Gender: _____

PPD (purified protein derivative) Test:
Required before beginning clinical courses
and every year thereafter
(You must attach documentation)

DATE GIVEN ____/____/____
DATE READ ____/____/____
____NEG ____POS

Chest X-ray (indicated only when skin test
is positive)

Date read: ____/____/____
____NEG ____POS

Provider's Signature:

Date signed: _____

Immunization: (Attach documentation for all)

DPT (*Diphtheria/Pertussis/Tetanus*): ____/____/____

Tetanus booster required within 10 years of
program entry: ____/____/____

MMR (*Measles/Mumps/Rubella*) Vaccine: Date
Received: ____/____/____
(or)

MMR Titer: ____/____/____ Results: _____

History of Varicella as a child (circle): Y N
or
Varicella vaccine: ____/____/____

Hepatitis B Vaccine: Have you had or are
you currently receiving it? (Attach
documentation)
____yes ____no

If yes, Date(s): 1st ____/____/____
2nd ____/____/____
3rd ____/____/____

Hepatitis Titer Done: ____/____/____
Results: _____

The vaccine is done to protect the student
from potential risks. It is MANDATORY
for Dental programs.

Waiver: I have been informed and
understand the risks and the benefits of the
hepatitis B vaccine and request it not be
given to me

Signature:

Date: _____

I am a student at Columbus Technical College
and I authorize CTC to release a copy of this
form to clinical sites as needed.

Student Signature:

Date: ____/____/____