

SCHOOL OF HEALTH SCIENCES

IMMUNIZATION FORM

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State: \_\_\_\_\_\_

Zip: \_\_\_\_\_\_\_\_\_\_\_\_ Phone: (\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_ Gender: \_\_\_\_\_\_\_\_\_\_\_\_\_

**IPPD** (*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 (*Diphteria/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 the college to release a copy of this form to the clinical sites as needed.

Student Signature:

Date \_\_\_/\_\_\_/\_\_\_