THIS SECTION TO BE COMPLETED BY HEALTH CARE PROVIDER

Student name: ______________________________________ **DOB**: ____________________________

To be completed by your Healthcare Provider – **ALL LAB REPORTS MUST BE ATTACHED**

Immunization & Titer Information ** (Titers are required where indicated)

1. MMR vaccine #1 _____________ MMR vaccine #2 _____________ OR

Measles (Rubeola) IgG date: __________ results: __________ if negative 2 MMRs are required #1__________ #2_________

Mumps IgG titer date: __________ results: _________ if negative 2 MMRs are required #1__________ #2_________

Rubella IgG titer date: __________ results: _________ if negative 1 MMRs is required #1__________

2. HEP B #1_______________ #2________________ # 3________________and

****Hep B surface antibody IgG titer** (not an antigen test) **date: ________________ results: _________________**

if negative Hep B #1 Booster date**:** _____________ titer after 1 month date: ____________ results: ____________

if negative Hep B #2_____________ Hep B #3____________________ titer date: ____________ results: _____________

3. Varicella vaccine #1 _____________ #2 __________ **OR** titer date: ____________ results: _______________

4. Flu Vaccine for all students that ARE NOT 100% remote: ___/___/___

5. COVID VACCINE -

Moderna #1 ____/____/____ #2____/____/____

Pfizer #1 ____/____/____ #2____/____/____

Johnson & Johnson (Janssen) #1____/____/____

Booster #1____/____/____

Other Immunizations Required

6. Tdap w/in the last 10 years __________________________ **(Td does not fulfill this requirement)**

7. Meningitis vaccine (ACWY) w/in the last 5 years _________________ **OR**

Men B series #1 ________________ #2 ____________________ **OR**

Sign the attached meningitis waiver

TB screening - must be within the last 12 months

8. PPD complete all blanks

Date placed __________ Date read ___________ mm of induration _______ Interpretation: Neg or Pos

Manufacturer______________ lot ____________exp. date_________________

If positive – must supply a negative quantiferon gold or T-spot

OR

Quantiferon Gold or T-spot date: ________________ results: ______________________________

Chest X-ray – required for positive Quantiferon Gold or T-spot Date: ______________ results: ____________________

Treatment for positive TB: ______________ name of medication: ______________________________

Date started: _________________ Date completed: ________________________ (include documentation)

PHYSICIAN OR HEALTH CARE PROVIDER (Must be signed & dated to be acceptable)

Printed Name: ____________________________________ Address: ______________________________

Signature: ______________________________ Date: ___________________ Phone #: ________________