

PROFESSIONAL STUDIES - IMMUNIZATION FORM

STUDENT NAME: _____ STUDENT ID# _____

	<u>Immunized</u>	<u>Not Immunized</u>	<u>Comments</u>
1. <u>Diphtheria/Pertussis/Tetanus Vaccine</u> The Primary Series with a Booster every 10 years			
2. <u>Polio Vaccine</u> Primary Series of IPV (Polio) or Oral Polio Vaccine			
3. <u>Measles</u> Two doses of live attenuated vaccine			
4. <u>Mumps</u> Two doses of live attenuated vaccine			
5. <u>Rubella</u> Two doses of live attenuated vaccine			
6. <u>Varicella Vaccination</u> (Chicken Pox)			
7. Influenza (seasonal)			
8. Influenza (H1N1)			
9. Hepatitis Serology			
a. HBsAb			
b. HBsAg			
10. <u>Hepatitis B Vaccine</u> Primary Series (3 doses)	1 st of Series Date	2 nd of Series Date	3 rd of Series Date
	D M Y	D M Y	D M Y
Immunization Notes			
11. <u>Tuberculosis Screening is mandatory</u> Within the last 6 months for Skin Test or 1 year for Chest X-Ray* (*must be done if skin test is positive)			
a. Mantoux Test	Skin Test Result		+ve <input type="checkbox"/> -ve <input type="checkbox"/>
	Date:		
a. Chest X-Ray	Chest X-ray result:		
	Date:		
b. TB Testing Notes			

Place Agency / Office Stamp Below:

Signature of Public Health Nurse or Doctor

Date: