Medical Professionals: Please read requirements thoroughly.

Immunizations and Tests Required by State Law/Clinical Facilities

Name: ______________________ **Date of Birth:** ______________

Measles, Mumps, Rubella (MMR)/Varicella vaccines if not given on same day MUST be 28 days apart.

ALL DATES MUST INCLUDE MONTH, DAY AND YEAR.

	Requirement	Documentation
Measles (Rubeola), Mumps & Rubella (MMR)	**A.** **Two** doses of Measles, Mumps, Rubella (MMR) vaccine on or after their first birthday and at least 28 days apart **OR**	Date #1:______/______/_________ Date #2:______/______/_________
	B. Serologic test <u>positive</u> (1.1 AI or greater) for Measles IgG antibody	Date of Collection:______/______/_________ ____Positive ____Negative
	B. Serologic test <u>positive</u> (1.1 AI or greater) for Mumps IgG antibody	Date of Collection:______/______/_________ ____Positive ____Negative
	B. Serologic test <u>positive</u> (10 IU/mL or greater) for Rubella IgG antibody	Date of Collection:______/______/_________ ____Positive ____Negative
Varicella	**A.** **Two** doses of Varicella vaccine on or after their first birthday and at least 28 days apart. (Only one dose of Varicella vaccine is needed if the student received first dose before the age of thirteen (13)). **OR**	Date #1:______/______/_________ Date #2:______/______/_________
	B. Serologic test <u>positive</u> (1.10 ISR or greater) for Varicella IgM antibody **OR**	Date of Collection:______/______/_________ ____Positive ____Negative
	C. Physician documented history of Varicella (Chicken Pox)	Disease Date:______/______/_________
Hepatitis B - 3 doses required	**A.** Dose 1 (initial dose)	Date #1:______/______/_________
	A. Dose 2 (minimum 4 weeks after date #1)	Date #2:______/______/_________
	A. Dose 3 (minimum 8 weeks after date #2 *and* minimum 16 weeks after date #1) **OR**	Date #3:______/______/_________ 3 doses required. 2-dose series not accepted.
	B. Serologic test <u>positive</u> (11.5 mIU/mL or greater)for Hepatitis B antibody	Date of Collection:______/______/_________ ____Positive ____Negative
Tdap	**A.** Must be current within the last 10 years.	Date:______/______/_________
Meningitis	**A.** For students under 21 years of age. Must be current within the last 5 years.	Date:______/______/_________
TB	**A.** TB Test must be completed within 180 days before the class start date	Result Date #1: ______/______/_________ ____Positive ____Negative _____Size
Flu	**A.** Current seasonal flu vaccine required for clinical rotations	Date:______/______/______ Lot:____________

Physician or Approved Licensed Health Professional Information: <u>Date of signature below must be after last immunization or additional immunization forms must be signed and dated separately.</u>

Provider's Printed Name:	STAMP HERE:
Clinic Address:	
Provider's Signature:	Date:______/______/_________