Central Community College Health Sciences
Immunization Record

Student name: _____________________________ Date: __________________

Date of Birth: ___________________________ Age: __________

MEASLES/MUMPS/RUBELLA (MMR)
For individuals born after Jan. 1957

One of the following is required:

Two required Immunizations: Or Positive Titer:

#1 Date: ___________________________ Measles Positive Titer - Date: __________________

#2 Date: ___________________________ Mumps Positive Titer - Date: __________________

Rubella Positive Titer - Date: __________________

VARICELLA (Chickenpox)
Two required immunizations:

#1 Date: ___________________________ Or History of chicken pox: Date: __________________

#2 Date: ___________________________ Or Positive antibody titer: Date: __________________

TETANUS/DIPHTHERIA/PERTUSSIS (Tdap)
Documentation of Tdap immunization within the past 10 years:
(If Tdap has not been previously administered to the student an interval of 2 years since the last TD booster is suggested.)

Date: ___________________________

HEPATITIS B
Hepatitis B # 1 - Date: ___________________________ Or Positive Antibody Titer - Date: __________________

Hepatitis B # 2 - Date: ___________________________ *If titer is negative, repeat the series and titer

Hepatitis B # 3 - Date: ___________________________

TUBERCULOSIS SKIN TEST (PPD)

° Initial 2-step screening - 2 separate PPD skin tests given and read at least 1 week apart OR 2 tests in a 12 month period
° Annual PPD screening after 2-step requirement met.

Results & Date read: Negative: ___________________________ Positive: ___________________________

If positive PPD skin test, documentation should include chest x-ray results and medical treatment received

Chest X-ray & Medications/Treatment - Date: ___________________________

INFLUENZA VACCINE (YEARLY) Must have documentation from provider

Vaccine Name: ___________________________ Lot #: ________ Date: ______________

TB testing is required yearly prior to first clinical rotation. Influenza vaccine is required yearly.

RETURN FORM TO: Program Director (Student is responsible for returning the completed form to Program Director)

Attach copies of actual records or provide healthcare provider’s signature verifying immunizations.

Healthcare Provider's Signature: ___________________________ Date: ______________

10/1/14