Immunization Record:

You may have your family physician complete and sign this form OR you may provide copies of the immunizations required.

(Copy of immunizations, Blood Titers, and TB screening from physician is acceptable in place of this form)

Name:	**Start Date:**
Department:	**DOB**
Title: Non Associate Educational Visitor	

Dates of Mandatory Immunizations or Blood Titer Results

MMR(measles, mumps, rubella)	**1.)**	**2.)**	
Varicella Vaccine:	**1.)**	**2.)**	**date of chicken pox disease:_____**
Hepatitis B	**1.)**	**2.)**	**3.)**
Tdap Vaccine	**1.)**		
Influenza	**1.)**		

Tuberculosis Testing or Screening:

PPD (Mantoux): Date Applied: _____Results _____mm

Quantiferon Gold test result (if history of a positive PPD skin test)_____

Physician's Signature _____Date_____