OFFICE USE ONLY

MRN:_______________________

Health Professions Immunization Form

REQUIRED – UFID NUMBER (8 digits):

☐☐☐☐-☐☐☐☐

Name: ____**Date of Birth:** ______________________ **Phone:** _______________________

Health Profession *(check one)*: ☐ Dental ☐ DAT ☐ Medicine ☐ PA ☐ Nursing ☐ Pharmacy ☐ PHHP

Vaccine Name	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Date (MM/DD/YYYY)	Titer Date & Result (Must include lab report)
1. MMR (Measles, Mumps, Rubella) (2 doses on or after 12 months of age)			--NOT APPLICABLE--	
2. Hepatitis B				
3. MCV4 (Menactra/Menveo)			--NOT APPLICABLE--	--NOT APPLICABLE--
☐ I have read the information about MCV4 (Menactra/Menveo) / Meningococcal Meningitis and decline receipt of this vaccine. ______________________________ ______________ Student Signature Date				
4. ☐ Td and/or ☐Tdap (Adacel/Boostrix) (Must have one instance of pertussis)		--NOT APPLICABLE--		--NOT APPLICABLE--
5. Varicella (Varivax)			--NOT APPLICABLE--	
6. Tuberculosis Screening: ***(see instructions on p.1)***				

TB Skin Test by TST (Mantoux)	#1	Date Placed	Date Read	MM	**Result:** Neg Pos
	#2	Date Placed	Date Read	MM	**Result:** Neg Pos
OR Interferon-based Assay (QFT or Tspot)		Date	Result	**Submit copy of lab report**	
Chest X-ray **(Only if positive TST or Lab Test)**		Date	Result	**Submit copy of x-ray report**	

SECTION B: Optional Immunization

COVID-19	Moderna			--NOT APPLICABLE--
	Pfizer			--NOT APPLICABLE--
	J&J		--NOT APPLICABLE--	

Important! Make a copy of this page and all lab reports to keep for your records.

An official stamp from a doctor's office, clinic or health department AND an authorized signature must appear here or this form will not be approved.

______________________________ ______________________________ ______________

Official Office Stamp Here **Physician or Authorized Signature** **Date**

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