Staff Immunization History Form

Name: _____ **Birthdate:** _____

I certify that the immunization information provided is correct. I give permission to the school district, school, preschool or early learning center to share immunization information with the Immunization Information System.

Signature: _____ **Date:** _____

MEASLES, MUMPS, AND RUBELLA (MMR)

One dose of MMR vaccine is recommended for all staff. Staff at high risk (nurses, international travelers, or college students) are recommended to get two doses. This vaccine is not required for those born before January 1, 1957.

Dose 1 date: _____ Dose 2 date: _____

Documentation of Immunity

☐ I certify that the person named above has laboratory evidence of immunity to measles, mumps, or rubella virus and does not need MMR vaccine.

☐ Titer (laboratory evidence of immunity) Result/Date:_____

_____	_____	_____
Licensed Health Care Provider Name (print)	Licensed Health Care Provider Signature	Date

VARICELLA (CHICKENPOX)

Two doses of varicella vaccine are recommended unless staff had verification of chickenpox disease or herpes zoster from a healthcare provider.

Dose 1 date: _____ Dose 2 date: _____ ☐ Date of Chickenpox disease:_____

Documentation of Immunity

☐ I certify that the person named above has laboratory evidence of immunity to varicella virus and does not need varicella vaccine.

☐ Titer (laboratory evidence of immunity) Result/Date:_____

_____	_____	_____
Licensed Health Care Provider Name (print)	Licensed Health Care Provider Signature	Date

HEPATITIS B

*For more information about Labor and Industries rules about the hepatitis B vaccine and potential occupational exposure to blood-borne pathogens, please go here: www.lni.wa.gov/safety/rules/chapter/823/

Three doses of hepatitis B vaccine are recommended or laboratory evidence of immunity.

Dose 1 date: _____ Dose 2 date: _____ Dose 3 date: _____

Documentation of Immunity

☐ I certify that the person named above has laboratory evidence of immunity to hepatitis B virus and does not need Hepatitis B vaccine.

☐ Titer(laboratory evidence of immunity) Result/Date: _____

_____	_____	_____
Licensed Health Care Provider Name (print)	Licensed Health Care Provider Signature	Date

TETANUS, DIPHTHERIA, PERTUSSIS (Tdap)/TETANUS-DIPHTHERIA (Td)

One Tdap recommended, then Td booster every 10 years.

Tdap date: _____ Td date (most recent): _____

INFLUENZA (FLU)

Flu vaccine recommended every year. Date (most recent): _____