Health Occupations
Physical & Immunization Form
400 Richards Road
Zanesville, OH 43701

Student's Full Name:_____ **Student's Program:**_____

has been examined on _____/_____/_____ and meets the requirements to attend a program in health occupations education without restrictions: ☐ Yes ☐ No

Physician or Nurse Practitioner are the only one(s) to fill out the information below:
PLEASE USE OUR FORMS ONLY – ***Do not*** submit separate physical or immunization forms unless they are exemptions.

Providers:
If you are not able to provide us a record for one or more of the immunizations below or the student has had the disease listed, please obtain a titer. List the date the titer was drawn along with result. If the student does not show immunity, a booster or immunization to provide necessary immunity is needed.

1. T-dap Vaccine – Tetanus, Diphtheria & Pertussis — Date:_____

2. Hepatitis B Vaccine (a waiver will be available) — Dates: 1st:_____ 2nd:_____ 3rd:_____

3. MMR Vaccines – Measles, Mumps & Rubella — Date:_____ Date:_____

4. Varicella - Chickenpox — Date:_____

5. Covid-19 Vaccine (exemptions available) — Date:_____ Date:_____ Booster:_____

6. 2-Step TB Mantoux (Use the back of this sheet only and please read the information at the top) (chest x-ray or QuantiFERON-TB Gold Plus are acceptable)

7. Seasonal Flu Vaccine will be required by mid-October. (exemptions available)

_____ _____
Physician's/Nurse Practitioner Signature — Date

By signing above, I acknowledge the student's physical ability to participate in the program and that all immunizations above are up to date or student shows immunity.

MID-EAST Career and Technology Centers

2-Step TB Mantoux Test

If you've previously had a 2-step TB and have followed up with your annual 1-step testing, then we only need you to obtain a 1-step. However, we will need proof of initial 2-step and each years 1-step since.

Please use this form only.

Student's Full Name:

1st step

Date Given:_____Site: Right / Left Forearm (please circle)

TUBERSOL: Lot:_____Exp:_____

Test Given By:_____

****MUST BE READ BY A PHYSICIAN, NURSE PRACTITIONER OR AN RN****

Date Read:_____

Results:_____mm

Read By:_____/_____
(please print) (signature)

Comments:_____

2nd step

Date Given:_____Site: Right / Left Forearm (please circle)

TUBERSOL: Lot:_____Exp:_____

Test Given By:_____

****MUST BE READ BY A PHYSICIAN, NURSE PRACTITIONER OR AN RN****

Date Read:_____

Results:_____mm

Read By:_____/_____
(please print) (signature)

Comments:_____

Only needed if unable to provide results via skin TB test

Chest X-Ray Date:_____ Results:_____

Revised: 11/13/2023