Immunization Record

Student Name ____ Date of Birth __________________

Submit a copy of high school, military, or other immunization records showing prior immunization against measles, mumps, rubella (MMR), tetanus, diphtheria, pertussis (Tdap), hepatitis B (3 series), and Varicella. If unable to provide a copy of prior immunization records, bring this form to your physician to be completed and signed, and then return the completed record to Scarlet Oaks. Proof of immunity to measles, mumps, rubella, hepatitis B, and Varicella by blood (titer) test is also acceptable with supportive laboratory documentation.

The student named above has been immunized against
MONTH, DAY, AND YEAR required

Measles/Mumps/Rubella

MMR 1 __/__/__

MMR 2 __/__/__

Or

MMR titers

Measles __ / __ / __ immune/non-immune

Mumps __ / __ / ___ immune / non-immune

Rubella __ / __ / ___ immune / non-immune

Varicella

Varivax 1 __/__/ ___

Varivax 2 __/__/ ___

Or

Varicella titer

Varicella ___/ ___/__ immune / non-immune

Tetanus/Diphtheria/Pertussis (within 10 years)

Tdap_____/___/______

Influenza (October – March)

Influenza___/__/__

Hepatitis B

HBV #1 __/__/___

HBV #2 __/___/__

HBV #3 __/__/__

Or

Hepatitis B titers

HBsAb ___/_/___

TB Skin Test/PPD/Chest X-ray within last 12 months

1st Step PPD (Date Read) __/__/__

2nd Step PPD (Date Read) __/__/__

Outcome _________

Or

QuantiFERON-TB or T-Spot (circle) __/__/__

Outcome _________

Or

Chest X-Ray __/__/___ Outcome__________

Healthcare Provider Signature: ______________________________________
Licensed Healthcare Provider (M.D., D.O., N.P., Or PA.)

Date_________________

Facility Name ________________________________ **Phone Number**________________________________

Address________________________________ **City/State/Zip** ________________________________