

Required Immunizations

Verify and document below (full dates needed) **by an appropriate healthcare professional**, or provide a copy of official documents for proof of immunity.

Name: _____ **Social Security No.:** _____ **Date of Birth:** _____

2- Step Tuberculin Skin Test Screening (1-3 week interval recommended)

Step1: Date administered: _____ 48-72 hour date **read:** _____ Result: _____ (Neg. or Pos.)

Professional's Signature: _____

Step2: Date administered: _____ 48-72 hour date **read:** _____ Result: _____ (Neg. or Pos.)

Professional's Signature: _____

*Chest X-ray (if needed) Date & Result: _____ Treatment Plan: _____

*CXR must be current within the last year. Please attach copy of CXR report.

****Hepatitis B series (three full dates):** 1) _____, 2) _____, 3) _____ *or include copy of Hepatitis B surface antibody titer report for proof of immunity.*

**Per CDC guidelines, three doses are required. Minimum of 1st dose documentation if new series needed to start class. Submit following vaccines upon completion for full immunity.

1st MMR: _____ **2nd MMR:** _____ *or include copies of titer reports on all three diseases for proof of immunity. (Two doses needed for all ages.)*

Childhood Chicken Pox: Yes No Date of Illness *(if known)* _____ **Healthcare Provider's Initials Required** _____

Varicella Vaccine (two dates): 1) _____, 2) _____ *(Include copy of varicella titer result for proof of immunity if drawn.)*

Healthcare Provider's Signature: _____ **Clinic Name:** _____