MERCY COLLEGE
OF HEALTH SCIENCES

Required Immunizations

Verify and document proof of immunizations below (full dates needed). Must be completed by an appropriate healthcare professional. You may also provide and submit a copy of official documents for proof of immunity.

Student Name: _____ **Date of Birth:** _____

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

Step 1: Date Administered: _____ Time Administered: _____

48-72 Hour Date Read: _____ Time Read: _____ Result: _____ (mm)

HealthCare Provider Signature: _____

Step 2: Date Administered: _____ Time Administered: _____

48-72 Hour Date Read: _____ Time Read: _____ Result: _____ (mm)

HealthCare Provider Signature: _____

*Chest X-Ray (if needed) Date & Result: _____

Treatment Plan: _____

*Chest X-Ray 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 Hep B surface antibody titer report for proof of immunity.

*Per CDC guidelines, three doses are required. Series must be started in order to participate in clinicals/practicums.

1st MMR: _____ **2nd MMR:** _____ or include copies of titer reports on all three diseases for proof of immunity.

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

Varicella Vaccine (two dates): 1) _____ 2) _____ or include copy of varicella titer result or history of disease for proof of immunity.

Healthcare Provider's Signature: _____ **Date:** _____