IMMUNIZATION RECORD

NAME_____ DATE OF BIRTH _____

ADDRESS_____ PHONE _____

CITY_____ STATE_____ ZIP _____

Signature_____ Date _____

Student signature authorizes the release of immunization records to the Center for Professional Education at UT-Chattanooga.

Submit a copy of high school, military or other immunization records showing prior immunization against measles, mumps, rubella, tetanus, diphtheria, pertussis, hepatitis B 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 the Center for Professional Education at UTC. Proof of immunity to measles, mumps, rubella, hepatitis B and varicella by blood test is also acceptable with supportive laboratory documentation.

The above named student has been immunized against

MONTH, DAY AND YEAR required

Measles/Mumps/Rubella

MMR1_____/_____/_____

MMR2_____/_____/_____

or MMR titers

Measles_____/_____/_____immune non---immune

Mumps_____/_____/_____immune non---immune

Rubella_____/_____/_____immune non---immune

Varicella

Varivax1 _____/_____/_____

Varivax2_____/_____/_____

Or

Varicella titer

Varicella_____/_____/_____immune non---immune

Hepatitis B

HBV1_____/_____/_____

HBV2_____/_____/_____

HBV3_____/_____/_____

or Hepatitis B titer

HBSAB_____/_____/_____immune non---immune

Tetanus/Diphtheria/Pertussis *Within last 10 years*

TDAP_____/_____/_____

TB Skin Test/ PPD / Chest X-ray

PPD (Date Read)_____/_____/_____

Outcome: _____

Chest X-Ray_____/_____/_____

Outcome: _____

FLU Vaccine (Required for student placements from October – March)

Flu _____/_____/_____

Physician/Nurse_____ **Date** _____

SIGNATURE REQUIRED

PRINT or STAMP MD name Street

City/State

Facility name Telephone