Immunization Verification Form

Approved School Representative or Student Coordinator Use Only

Name of Student_____ **School**_____

Please Print

Please insert dates and check boxes below as applicable. **Current**

COVID-19 Vaccine **Yes☐ No☐**

Pfizer 1st dose date 1 ____/____/____ Pfizer 2nd dose date____/____/____ Pfizer booster dose date_____

Moderna 1st dose date 1 ____/____/____ Moderna 2nd dose date___/____/____ Moderna booster dose date_____

Johnson & Johnson immunization date ____/____/____

MMR (measles, mumps, rubella) **Yes☐ No☐**

MMR Record 1 ____/____/____

Record 2 ____/____/____

Use below **only** if measles, mumps and rubella vaccinations were administered separately.

Measles ____/____/____, mumps___/___/____, rubella___/___/____

Measles ____/____/____, mumps___/___/____, rubella___/___/____

OR

Positive titer dates for Measles ____/____/____, mumps___/___/____, and rubella___/___/____

Varicella (chickenpox) **Yes☐ No☐**

Vaccination dates____/____/____AND ____/____/____(two recommended by the CDC)

OR titer date____/____/____**OR** recollection of having the disease _____

(Year or age had disease)

Hepatitis B **Yes☐ No☐**

Record 1____/____/____Record 2____/____/____Record3____/____/____**and** positive Titer date ___/____/____

OR Can be declined but student must sign a declination. Date signed____/____/____

Tetanus w/ Pertussis (Tdap) ***Note this must be Tdap not TD or DPT*** **Yes☐ No☐**

Date shot received____/____/____

Record of current flu shot **Fill in dates vaccinations were administered for every year the student is in clinical rotations.**

First Year	
Second Year	
Third Year	
Fourth Year	

TB (PPD-tuberculosis) Record of a negative TB test within the last twelve months or a negative Quantiferon TB test is required. Or fill out Positive Responder Form. Ask Community Medical Center for this form if you have a positive test. AND each year a student attends the same program they must fill out a TB questionnaire provided by the COMMUNITY MEDICAL CENTER. This questionnaire will then be sent to Community Medical Center' appropriate department along with a copy of the original negative TB test to be reviewed and a determination will be made by that department if an additional test is necessary based on the risk factors stated in the questionnaire

Date of First Negative TB Test Results	Returning Student Annual TB Questionnaire Signed Date	ORGNAIZATION Approval Date for Questionnaire	Date of Negative Quantiferon

Proof of this information is to be kept and maintained by the school unless other arrangements have been made with the ORGANIZATION. Actual immunization records are not to be submitted to the ORGANIZATION unless prior arrangements have been made. By signing below, I am verifying that proof of this information is on file with the school or facility or the records have been submitted to the ORGANIZATION. If requested, we will provide these documents to the ORGANIZATION within one business day of the request for random audits. The school will be responsible to keep these records up to date and inform the student in advance when an immunization expiration date is approaching.

School Representative Signature _____ Date _____

Print Name _____ Title _____

Phone Number _____ Email address _____

Updated 08/24/2021