

(Patient Identification)

IMMUNIZATION DOCUMENTATION FORM

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. If your doctor cannot complete/sign this form please bring documentation of all required vaccines/tests

COVID-19 VACCINES REQUIRED

1st vaccination ___/___/___ Manufacturer _____ Lot# _____ Booster ___/___/___
2nd vaccination ___/___/___ Manufacturer _____ Lot# _____ Manufacturer _____ Lot# _____

INFLUENZA VACCINE REQUIRED

vaccination ___/___/___

MMR VACCINATIONS

1st vaccination ___/___/___
2nd vaccination ___/___/___

OR

POSITIVE TITER

Date of Measles titer ___/___/___ Immune Not immune
Date of Mumps titer ___/___/___ Immune Not immune
Date of Rubella titer ___/___/___ Immune Not immune

VARICELLA VACCINATIONS

1st vaccination ___/___/___
2nd vaccination ___/___/___

OR

POSITIVE TITER

Date of Varicella titer ___/___/___ Immune Not immune

Tetanus diphtheria Td

Date of last booster dose ___/___/___

OR

Tetanus diphtheria acellular pertussis Tdap

Date of vaccine ___/___/___

**MUST BE WITHIN
THE LAST 10 YEARS**

TUBERCULOSIS: ONE IGRA BLOOD TEST OR TWO TUBERCULIN SKIN TESTS WITHIN THE PAST 12 MONTHS

QuantiFERON Gold (date) ___/___/___ **OR** PPD 1st (date) ___/___/___ Result (circle) Positive Negative (mm)
Result (circle) Positive Negative

PPD 2nd (date) ___/___/___ Result (circle) Positive Negative (mm)

BCG History: (circle) YES NO

Note- PPD skin tests must be two weeks apart

If positive IGRA blood test, Chest x-ray must be within 12 months

Chest x-ray (date) ___/___/___

HEPATITIS B VACCINATION: Hepatitis B Surface Antibody Titer (needed only if employee will be exposed to blood/body fluids on the job)

History of Hepatitis B infection? (circle) Yes No

Previously vaccinated (circle) Yes No Unknown

1st Dose ___/___/___

4th Dose ___/___/___

2nd Dose ___/___/___

5th Dose ___/___/___

3rd Dose ___/___/___

6th Dose ___/___/___

Titer Date ___/___/___

Titer Date ___/___/___

Titer Result (circle) Positive Negative

Titer Result (circle) Positive Negative

Name of Health Care Provider (print)

Telephone Number

Address

Signature of Health Care Provider

Date/Time

(Patient Identification)

IMMUNIZATION CONSENT/DECLINATION FORM

CONSENT

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine checked above be given to me or to the person named below for whom I am authorized to make this request.

Employee Signature

Date/Time

Type of Vaccine: MMR

#1 Date _____ Manufacturer _____ Lot# _____ Exp. Date _____ Site _____ VIS _____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot# _____ Exp. Date _____ Site _____ VIS _____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

Type of Vaccine: Td or Tdap

Manufacturer: _____ vis _____

Date _____ Lot# _____ Exp. Date _____ Site _____ Provider _____

Type of Vaccine: Varicella

#1 Date _____ Manufacturer _____ Lot# _____ Exp. Date _____ Site _____ VIS _____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot# _____ Exp. Date _____ Site _____ VIS _____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

DECLINATION

I understand the information provided and explained to me on the vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine: (circle) MMR Varicella Td or Tdap

Employee Signature

Date/Time

Reason for Declination: _____