Immunization Verification Form

COMMUNITY MEDICAL CENTER
From day one.

*****See approved requirements in the Resident Checklist/Orientation Manual.*****

Approved School Representative or Resident Coordinator Use Only

Name of Resident_____ **School**_____
Please Print

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

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 resident 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 2020