Morgan Community College
Health/ Immunization Record

Last Name: _____First Name: _____ Middle: _____

Date of Birth: _____

I give consent for the MCC health program to share the results of the immunizations with clinical agencies as requested.

Student Signature

Students must **submit proof of the following immunizations and complete this form**. If an immunization record is unavailable, the student must have titers drawn that show immunity or receive the immunizations. If a titer does not indicate immunity, the immunizations must be done. A health care provider (MD, NP, PA, or Occupational Health RN) **MUST** verify information and sign this document.

The following is to be completed and signed by a health care provider:

1. Immunization History

DATE TAKEN:

A. Tetanus, Diphtheria, Pertussis (Tdap)
or (Tdap) *booster must be within the last 10 years.* _____
MO/YR

B. MMR (Measles-Mumps-Rubella)
Must have 2 doses of MMR, at least one-month apart Dose #1 _____ Dose #2 _____
MO/YR MO/YR

C. Varicella (Chickenpox)
*Proof of disease DOES NOT constitute immunity. Student must have either a titer drawn or receive the immunizations. The titer must indicate immunity; if it does not, must have two doses of individual varicella vaccine.

Must have 2 doses at least four weeks apart Dose #1 _____ Dose #2 _____
MO/YR MO/YR

D. Hepatitis B
*Students may choose to decline this immunization; however, a waiver form must be signed.
See Student Success Advisor for this form. *The hepatitis B series consists of three doses.*
The second dose should be 1-2 months after the initial and the third dose in 4-6 months.

Dose #1 _____ Dose #2 _____
MO/YR MO/YR

Dose #3 _____
MO/YR

E. COVID-19 documentation of primary series and booster.

Dose #1 _____ Manufacturer _____
MO/YR

Dose #2 _____ Manufacturer _____
MO/YR

Most Recent booster _____ Manufacturer _____
MO/YR

Titers: TO BE COMPLETED IF immunization records are unavailable. The student must have titers drawn that show immunity or receive the immunizations. If a titer does not indicate immunity, the immunizations must be done.

Tetanus, Diphtheria, Pertussis
Report of positive immune titer _____ OR if not immune, one dose of individual tetanus, diphtheria, pertussis vaccine
MO/YR

Dose #1 _____
MO/YR

Measles (Rubeola)
Report of positive immune titer _____ OR if not immune, two doses of individual rubeola vaccine
MO/YR

Dose #1 _____ Dose #2 _____
MO/YR MO/YR

Mumps
Report of positive immune titer _____ OR if not immune, two doses of individual mumps vaccine
MO/YR

Dose #1 _____ Dose #2 _____
MO/YR MO/YR

Rubella (German measles)
Report of positive immune titer _____ OR if not immune, two doses of individual rubella vaccine
MO/YR

Dose #1 _____ Dose #2 _____
MO/YR MO/YR

Varicella (Chickenpox)
Report of positive immune titer _____ OR if not immune, two doses of individual varicella vaccine
MO/YR

Dose #1 _____ Dose #2 _____
MO/YR MO/YR

Hepatitis B
Report of positive immune titer _____ OR if not immune, three doses of individual Hep B vaccine
MO/YR

Dose #1 _____ Dose #2 _____ Dose#3_____
MO/YR MO/YR MO/YR

2. TB REQUIRED FOR ALL STUDENTS YEARLY:

Option #1 Skin Testing

If you have never had a TB test, or if it has been over 1 year, since you had a TB test, you must now have a **2-step TB test**. If you have had a TB w/in 1 year a 1-step TB is required. Please record date of last TB if within 1 year _____.

Tuberculin Skin Test:

Date Given: _____ Date Read: _____

Mo Day Yr Mo Day Yr

RESULTS: _____mm (record actual mm of induration, if no induration write 0)

INTERPRETATION: _____Positive _____Negative

2nd Step, if required must be completed within 1 – 3 weeks of 1st step

2nd Tuberculin Skin Test:

Date Given: _____ Date Read: _____

Mo Day Yr Mo Day Yr

RESULTS: _____mm (record actual mm of induration; if no induration write 0)

INTERPRETATION: _____Positive _____Negative

Option #2 Quantiferon TB Gold or T-SPOT.TB (Yearly)

Date: _____

Mo Day Yr

INTERPRETATION: _____Positive _____Negative

A chest X-ray is required if TB skin test, Quantiferon, or T-SPT results are positive or if PPD cannot be performed. A chest X-ray report must be submitted with a signed statement from a physician stating that the individual is symptom free and safe for clinical experiences. The Chest X-ray must have been done within the last year or a signed statement from a physician recommending that one **not** be done and verification that the individual is symptom free and safe for clinical experiences.

Signature of a health care provider is required to validate the above information is correct. The provider must be a MD, NP, PA or Occupational Health RN.

Health Provider:

_____ _____

Print Name **Date**

_____

Signature

_____ _____

Address **Phone**