

Immunization Form:

Name: _____ Social Security Number: _____

Date of Birth: _____

Proof of immunization is required for admission into any Health Education Program that includes a clinical experience.

Tuberculin Skin Test (PPD) *within the 3 months prior to clinical experience* (**REQUIRED**):

Date given: _____ Date read: _____ Results: _____

Alternative: Chest x-ray within the last 5 years

Date given: _____ Date read: _____ Results: _____

Hepatitis B (**RECOMMENDED**)

Date(s) of immunization 1) _____ 2) _____ 3) _____

Alternative: History of disease or Positive Titer results

History of Disease: Date _____

Date of Titer: _____ Results: _____

Signature of Medical Professional
Or Office Stamp

Date