Name: ______________________________ SS# or Student ID: ______________ Date of Birth: ____________

Last First Middle/Maiden MM/DD/YYYY

SECTION A: Required Immunization--Must be completed by MD/PA/NP/RN/Health Dept. Representative

Measles Vaccine or MMR	OR	Measles Antibody
Date 1: ______ / ______ / __________ Date 2: ______ / ______ / __________		Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative
Mumps Vaccine	**OR**	**Mumps Antibody**
Date 1: ______ / ______ / __________ Date 2: ______ / ______ / __________		Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative
Rubella Vaccine	**OR**	**Rubella Antibody**
Date: ______ / ______ / __________		Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative

History of Chicken Pox OR Varicella Vaccine		OR	Varicella Antibody
☐ Yes ☐ No	Date 1: ______ / ______ / __________ Date 2: ______ / ______ / __________		Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative

Tetanus		
Td	**OR**	**Tdap**
Date: ______ / ______ / __________ (required every 10 years)		Date: ______ / ______ / __________

TB Skin Test (TST)	
Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative _____ mm Induration Date: ______ / ______ / __________ Results: ☐ Positive ☐ Negative _____ mm Induration	If positive, CXR date and result: ______________ Treatment: ____________________

SECTION B: Recommended Vaccines—(NOT REQUIRED)

Hepatitis B		
Vaccine	**OR**	**Antibody**
Date 1: ______ / ______ / __________ Date 2: ______ / ______ / __________ Date 3: ______ / ______ / __________		Hep B Antibody Date 1: ______ / ______ / __________ Results: ☐ Positive ☐ Negative

Seasonal Flu
Date: ______ / ______ / __________

______________________________ ______________ (   ) ______________

Health Care Provider Signature/Stamp **Date** **Telephone Number**

SECTION C: Personal Health History – To be completed by the applicant

Do you have any disease/condition/injury for which you are being treated or periodically evaluated? ☐ Yes ☐ No
If yes, please explain: ____
____
____
____

Are you taking any medication(s) on a regular basis? ☐ Yes ☐ No
If yes, please list all medication(s) and dosage: ____
____
____
____

Have you had or are you being treated for psychiatric or emotional conditions? ☐ Yes ☐ No
If yes, please explain: ____
____
____
____

Do you have any allergies: ☐ Yes ☐ No
If yes, please list:
☐ Drug ____
☐ Food ____
☐ Other ____

If you answered **YES** to any of the above questions, a statement from your physician may be required.

I,_________________________________, submit this Personal Health History as being accurate and complete. I understand that falsification or inaccurate information may result in dismissal from the program.

_____________________________ _____________________ (____)_____________________
Applicant Date Telephone Number

Student Additional Information:

Measles, Mumps, Rubella (MMR) – Must provide:

- Documentation of 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine after 1st birthday **OR**
- Documentation of positive antibody to measles, mumps, and rubella **OR**
- If no documentation, 2 measles vaccines, 2 mumps vaccines and 1 rubella vaccine is required

Varicella (Chicken Pox) – Must provide:

- Documentation of 2 varicella vaccines if never had chicken pox **OR**
- Documentation from healthcare provider if history of chicken pox **OR**
- Documentation of varicella positive antibody if history of chicken pox

Tetanus, Diphtheria, Pertussis – Must provide:

- Documentation of a Td or Tdap that is current within 10 years.
- Individuals should receive booster every 10 years.

TB Skin Test (TST) –Must provide:

- Documentation of receiving a TB skin test in the past 12 months. Only 1 additional skin test is required. **OR**
- Documentation of 2 step TST is required:
  - **Step One:** First test to be administered and results to be read within 48-72 hours. If positive, TB questionnaire and chest X-ray required. If result is negative, proceed to Step Two.
  - **Step Two:** Second test to be administered in 1 to 3 weeks after first test and be read within 48-72 hours. If second test is positive, TB questionnaire and chest X-ray required.