Banner Health®

Immunization Form

Name ______________________ **DOB** __________

School/Company ______________________ **Program/ID#** ______________________

		Required Immunizations
Titer	***Dates of Immunization***	***Immunization** and explanation of requirement*
☐	#1 ________ #2 ________	**MMR (*Measles/Rubeola, Mumps & Rubella*)** *One "series" of immunizations includes two immunizations for each disease on separate dates at least 28 days apart.*
☐	#1 ________ #2 ________	**Varicella *(chickenpox)*** *One "series" of immunizations includes two immunizations 30 days apart.*
☐	#1 ________ #2 ________ *Date of last Chest X-ray* ________ *Date of last annual test* ________	**Tuberculosis (TB)** *Two-Step TB Skin Test consisting of an initial TB skin test and a boosted TB skin test 1-3 weeks following the first test.* ***OR*** *Negative Two-Step TB Skin Test **and** recent annual testing.* ***OR*** *Negative chest X-ray **and** annual documentation of a TB disease-free status by completing a Tuberculosis Screening Questionnaire.* ***OR*** *Documentation of a recent negative result from an IGRA test (Quantiferon, T-Spot)*
☐	#1 ________ #2 ________ #3 ________ ☐ Decline	**Hepatitis B:** *One "series" of Hepatitis B immunizations includes three injections, an initial injection followed by a second injection given 1 to 2 months after the first dose and a third injection44 to 6 months after the first.* ***A signed Declination form must be and on file to receive an exemption.***
	Date of immunization ________	**Influenza Vaccine:** *During flu season, Dec. 1st thru Mar 31ss , students will be required to receive a flu vaccination.* ***Forms available upon request for medical or religious exemptions.***

		Recommended Immunizations
☐	Tdap ________ Td ________	**Tetanus/Diphtheria/Pertussis (Tdap):** *One-time adult dose of Tdap (age 19 or older), followed by a Td booster every 10 years.* *Tdap = Tetanus / Diphtheria / Pertussis, Td = Tetanus / Diphtheria*

Medical Provider Signature & Title ______________________ **Date** __________

Student/Employee Comments:

Staff/ Provider Comments: