CARILION IMMUNIZATION RECORD

Section I: To be completed by applicant ***Applicants MUST have had all the immunizations listed below.***

Printed Name:	
Date of Birth (MM/DD/YY):	School-Provided E-mail Address:
Rotation Start Date (MM/DD/YY):	

Section II: To be completed by approved School Representative or Health Care Provider
(NO OTHER IMMUNIZATION FORMS are accepted. Instead summarize immunizations below.)

Check appropriate circle.	Yes	No
• **MMR** ***Two Doses of MMR Vaccine*** (The 1st vaccination was received on or after the first birthday and the 2nd vaccination was received at least 28 days after the first dose.)	O	O
Alternative Regimen **1. Measles (Rubeola): Two Vaccines are required or Positive Serology** (The 1st vaccination was received on or after the first birthday and the 2nd vaccination was received at least 28 days after the first dose.)	O	O
2. Mumps : One dose of Vaccine on or after 1st birthday **or Positive Serology**	O	O
3. Rubella: One dose of Vaccine on or after 1st birthday **or Positive Serology**	O	O
• **Tuberculosis** (Initial and yearly tests more than 4 months out of date must be the 2-Step Test.) Negative results dated within 12 months of rotation dates in Section I above.	O	O
If No above, negative results required on chest x-ray	O	O
• **Varicella** ~ ***Vaccines or positive serology or had disease***	O	O
• **Polio** ~ ***Primary series of Vaccine***	O	O
• **Tetanus-Diphtheria** ~ ***Primary series of Td immunizations and a Td or Tdap booster dose administered within 10 year of coming to Carilion***	O	O
• **Hepatitis B** ~ ***Vaccines or Positive Serology***	O	O
• **Influenza** (The CDC requires us to report the following information.) ***Most recent vaccination is dated (MM/DD/YY)_____.***		
Most recent vaccination will be effective through rotation dates listed in Section I above.	O	O
The school requires that students receive vaccinations between October 1st and March 31st.	O	O
Student refused vaccination for reasons other than medical contraindication.	O	O
Student refused vaccination for medical contraindication related to _____.	O	O

Signature of Approved School Representative or Health Official Completing This Form		Date (MM/DD/YY)
Printed Name	Title	Phone
Name of School or Health Care Provider's Address	School Seal (Optional for Health Care Provider)	

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