



**Immunization Record Form for Job Shadowing**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Home Address and Phone: \_\_\_\_\_

Dep't Shadowing: \_\_\_\_\_ Birthdate/Age \_\_\_\_\_

*We are dedicated to protecting you and our patients from infectious disease. Documentation of the following immunizations is required prior to beginning your shadowing/observation experience. A photocopy of your immunization record may be attached to this form as proof of immunization.*

	<i>Hepatitis B (series of 3 shots; you may shadow after proof of the 1<sup>st</sup> shot)</i>	<i>Varicella (2 shots) (chicken pox) or date of disease</i>	<i>MMR (2 shots)</i>	<i>TD (before 2006) or Tdap within 5 years.</i>	<i>Seasonal flu shot if during current active flu season in Greene County</i>	<i>Current negative TB or treated within past 12 months.</i>
<i>Date(s) of vaccination</i>						
<i>Clinic or physician's office where vaccinated</i>						