PLATT COLLEGE

Standardized Immunization Form: All Immunizations

Patient Section

Last Name:		**First Name:**		**Middle Initial:**	
DOB:		**Street Address:**			
Last 4 SS#:		**City:**			
Phone:		**State:**			
Email:		**ZIP Code:**			

Below Section: MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER

Authorized Signature:	
Printed Name:	
Title:	
Address Line 1:	
Address Line 2:	
City:	
State:	
ZIP Code:	
Phone:	
Fax:	
Email Contact:	

Authorized Signature of Healthcare Provider: _____

Date: _____

PLATT COLLEGE

Name: _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

MMR (Measles, Mumps, Rubella) – Two (2) doses of MMR vaccine or two (2) doses of Measles, two (2) doses of Mumps and one (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps, and/or Rubella			
Option 1	Vaccine	Date	Documentation
MMR -2 doses of MMR vaccine	MMR Dose #1	_____/_____/_____	
	MMR Dose #2	_____/_____/_____	
Option 2	Vaccine or Test	Date	
Measles -2 doses of vaccine or positive serology	Measles Vaccine Dose #1	_____/_____/_____	
	Measles Vaccine Dose #2	_____/_____/_____	
	Serologic Immunity (IgG, antibodies, titer)	_____/_____/_____	Must Provide Documentation
Mumps -2 doses of vaccine or positive serology	Mumps Vaccine Dose #1	_____/_____/_____	
	Mumps Vaccine Dose #2	_____/_____/_____	
	Serologic Immunity (IgG, antibodies, titer)	_____/_____/_____	Must Provide Documentation
Rubella -2 doses of vaccine or positive serology	Rubella Vaccine Dose #1	_____/_____/_____	
	Rubella Vaccine Dose #2	_____/_____/_____	
	Serologic Immunity (IgG, antibodies, titer)	_____/_____/_____	Must Provide Documentation

Hepatitis B Vaccination – Three (3) doses of Hepatitis B vaccine or serologic proof of immunity for Hepatitis B See: http//www/cdc.gov/mmwr/pdf/rr/rr6210.pdf for more information			
Hepatitis B Series		Date	Documentation
	Hepatitis B Vaccine Dose #1	_____/_____/_____	
	Hepatitis B Vaccine Dose #2	_____/_____/_____	
	Hepatitis B Vaccine Dose #3	_____/_____/_____	
	Quantitative Hep B Surface Antibody	_____/_____/_____	Must Provide Documentation

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Tetanus-Diphtheria-Pertussis Vaccination – One (1) dose of adult Tdap			
Tetanus-Diphtheria-Pertussis Vaccination		Date	Documentation
	Tdap Vaccine (Adacel, Boostrix, etc)	_____/_____/_____	

Tuberculosis Screening – TB Skin Tests/PPDs are required annually: TB or Chest X-Ray must be negative *Some clinical sites will not accept the Quantiferon-TB Blood Test which could result in delay of clinical placement.					
Option 1		Date Placed	Date Read	Reading	Interpretation
Tuberculosis Skin Test	TB Skin Test/PPD Given	___/___/___	___/___/___	_____ mm	☐ Positive ☐ Negative ☐ Equivocal
Option 2		Date Taken	Interpretation		Documentation
Chest X-Ray	Chest X-Ray Taken	___/___/___	☐ Normal ☐ Abnormal		Must Provide Documentation

Varicella (Chicken Pox) Vaccination – Two (2) doses of vaccine or positive serology			
Varicella Vaccination		Date	Documentation
	Varicella Vaccine Dose #1	_____/_____/_____	
	Varicella Vaccine Dose #2	_____/_____/_____	
	Serologic Immunity (IgG, antibodies, titer)	_____/_____/_____	Must Provide Documentation

Name: _____ **Date of Birth:** _____

(Last, First, Middle Initial) (mm/dd/yyyy)

Influenza Vaccine – One (1) dose annually each fall			
Influenza Vaccine		Date	Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation
	Flu Vaccine	_____/_____/_____	Must Provide Documentation