IMMUNIZATIONS FORM
Pat Capps Covey College of Allied Health Professions

University of South Alabama
5721 USA Drive North
Mobile, Alabama 36688-0002

Directions/Disposition: Part A is to be completed by the students, Parts B, C (initial test only) & D by the healthcare provider, and Parts C (annual tests) & E by department designee. Original is maintained in the permanent student record.

Part A. Student Information (please print):

Name: ______________________________ **JAG#:** ____________
(last, first, MI)

Birth date: ____________ **Academic Department:** ______________________
(month, day, year)

Permanent Address: ____
(street, city, state, zip)

Phone numbers: (1) Home: ____________ **(2) Cell:** ____________
(include area code if not 251)

Part B. Immunization Information (please print):

Vaccination[1]	**1st immunization**		**2nd immunization**		**3rd immunization**	
	Vaccine type	Date (mm/dd/yyyy)	Vaccine type	Date (mm/dd/yyyy)	Vaccine type	Date (mm/dd/yyyy)
Measles (rubeola)[2]						
Mumps[2]						
Rubella (German measles)[2]						
MMR (trivalent)[2]						
Tdap (DPT)[3] /Td booster (2nd/3rd)						
Hepatitis A/B Virus[4]						
Varicella (chicken pox)						
Meningitis (meningococcal) [5]						
Other (specify ____________)						

Part C. Vaccination Titers (please print):

Agent titered	**Date** (mm/dd/yyyy)	**Result interpretation**[4]	
Rubella		☐ positive	☐ negative
Measles		☐ positive	☐ negative
Varicella		☐ positive	☐ negative
Hepatitis B virus		☐ positive	☐ negative

Part D. Tuberculosis (TB) Testing

	Date (mm/dd/yyyy)	**Result (in mm)**	**Interpretation**	
Initial TB Skin test	____________	________	☐ positive[6]	☐ negative
Repeat TB Skin test[7]	____________	N/A	☐ positive[6]	☐ negative
Annual TB Skin test	____________	________	☐ positive[6]	☐ negative
Annual TB Skin test	____________	________	☐ positive[6]	☐ negative
Chest X-ray/IGRA test	____________	N/A	☐ positive	☐ negative

Part E. Influenza Vaccination

1st annual ____________ 2nd annual ____________ 3rd annual ____________
Date (mm/dd/yyyy) Date (mm/dd/yyyy) Date (mm/dd/yyyy)

Part F. Provider Certification

____
Physician/HCP (or authorized signature)

____________ ____________________
Date **License #/State** (or stamp)

Provider Stamp (here)

Students - Make a copy of completed form for your records & deliver original to your department. ***Form modified 07/17/20***

Footnotes:

[1] Immunizations not listed can be added to the back of this form by indicating immunization name and date performed.

[2] Two doses of measles vaccine are required for students born after 1956, one dose administered after 1980, one dose given as part of a MMR.

[3] A one-time dose of Tdap (DPT) is required for all employees/students who have not received Tdap previously or cannot show proof of receiving. A Td booster is required every 10 years thereafter by IM (intramuscular).

[4] A Hepatitis B virus (HBV) vaccination is required but combination HBV & Hepatitis A virus (HAV) Twinrix (HAV/HBV) is highly recommended.

[5] A single dose immunization is sufficient if received within last 5 years.

[6] Positive PPD result must be followed up with a chest X-ray or an Interferon-Gamma Release Assay (IGRA) whole blood test.

[7] All new employees/students must get a tuberculin skin test (TST). Annual retesting is required for individuals entering clinical sites.