

ELAC EMT Immunization Requirements

Student ID:	Date of Birth (mm/dd/yy):	Name (first last):
-------------	---------------------------	--------------------

This form must be signed by a healthcare provider attesting all information is true and accurate OR student may supply all required source documents.

REQUIRED VACCINATIONS FOR ALL STUDENTS						
Vaccination	Titer Result Date	Titer Result	If not immune, 1st dose of vaccine		Date received	Vaccine received
Measles		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal	OR	X 2	(Dose 1 must be on or after age one)	
Mumps		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal	OR	X 2	(Dose 1 must be on or after age one)	
Rubella		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal	OR	X 2	(Dose 1 must be on or after age one)	
Varicella		<input type="checkbox"/> Immune <input type="checkbox"/> Non-Immune <input type="checkbox"/> Equivocal	OR	X 2	(Dose 1 must be on or after age one)	
Tdap (Note: Td, DTaP, Dtap do not satisfy the requirement)		NON-Healthcare Professional Students ONE DOSE ON OR AFTER AGE 11				<input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix <input type="checkbox"/> _____
		Healthcare Professional Students (DGSOM, Dental, Nursing, Social Welfare) ONE DOSE IN THE LAST 10 YEARS				<input type="checkbox"/> Adacel <input type="checkbox"/> Boostrix <input type="checkbox"/> _____
Vaccination	Date received	Manufacturer	Lot #		OR	Declination
Seasonal Influenza	(Dose must be on or after start of school year)					<input type="checkbox"/> I am voluntarily choosing to decline the seasonal influenza vaccine.

ADDITIONAL REQUIREMENTS FOR ALL HEALTHCARE PROFESSIONAL SCHOOL STUDENTS (EMT) FIRST DOSE SUFFICES

Hepatitis B Immunity	Date (MM/DD/YY)	HbsAb Titer	If HbsAb non-reactive, or no vaccine documented, must vaccinate	Date (MM/DD/YY)	Vaccine received
Hepatitis B Surface Ab Titer (HbsAb) Anti-HBs		<input type="checkbox"/> Reactive <input type="checkbox"/> Non-Reactive	3 dose series (Engerix-B or Recombivax) Or 2 dose series (Hepilisav-B)		<input type="checkbox"/> Engerix-B <input type="checkbox"/> Recombivax <input type="checkbox"/> Hepilisav-B
					<input type="checkbox"/> Engerix-B <input type="checkbox"/> Recombivax <input type="checkbox"/> Hepilisav-B
					<input type="checkbox"/> Engerix-B <input type="checkbox"/> Recombivax <input type="checkbox"/> Hepilisav-B

TUBERCULOSIS (TB) HEALTH ASSESSMENT FORM:

Required for Healthcare Professional Students (EMT Students)

I have a history of a positive TB Skin Test, T-Spot or Quantiferon Blood Test (circle one): No Yes. If "yes"

Date: _____

TUBERCULOSIS TESTING (date of test must be within the 6-month period preceding entry to ELAC EMT)

Tuberculin Skin Test (option for NON-Healthcare Professional Students only)	Date placed: (MM/DD/YYYY)	Date read: (MM/DD/YYYY)	Result (mm induration):	Interpretation: <input type="checkbox"/> Negative <input type="checkbox"/> Positive*
OR				
Quantiferon or T-spot (Interferon Gamma Release Assay – IGRA) <i>Required for Healthcare Professional Students or students with a history of BCG Vaccine.</i>	Date of test: (MM/DD/YYYY)	Name of test: <input type="checkbox"/> Quantiferon <input type="checkbox"/> T-Spot	Result: <input type="checkbox"/> Negative <input type="checkbox"/> Positive* <input type="checkbox"/> Indeterminate If indeterminate, repeat test in one month or obtain chest x-ray	
Chest X-Ray (*Required if TBST or IGRA are positive; previous treatment for TB; or if "yes" answers to symptoms)	Date of chest x-ray (MM/DD/YYYY)		Result: <input type="checkbox"/> Negative <input type="checkbox"/> Abnormal Must attach written radiology chest x-ray report in English (DO NOT SEND FILMS/CD of actual x-ray)	

I ATTEST THAT ALL DATES AND IMMUNIZATIONS LISTED ON THIS FORM ARE CORRECT AND ACCURATE.

I ALSO ATTEST STDENT ABOVE IS EITHER IMMUNE OR HAS RECEIVED ALL UPDATED IMMUNIZATIONS.

Provider's Signature: _____

Provider's Name (MD/DO/NP/RN): _____

Date: _____

Practice Stamp (or address/phone): _____