

# McLennan Community College

## IMMUNIZATION RECORD FOR HEALTH CAREERS STUDENTS

**NAME OF STUDENT:** \_\_\_\_\_ **SS #** \_\_\_\_\_  
(print)

**IMMUNIZATIONS:**

**T.B. Test (Annual Update Required)** Date \_\_\_\_\_ Results \_\_\_\_\_

or Chest X-ray: Date \_\_\_\_\_ Findings \_\_\_\_\_

**Tetanus-diphtheria toxoid (Td):** Date \_\_\_\_\_ (within last 10 years)

**Measles/Mumps/Rubella:**

- a. Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of **two doses** of **measles-containing vaccine administered since January 1, 1968**. Serologic confirmation of immunity to measles is acceptable.
- b. **Prior to patient contact**, students must show proof of either **one** dose of **rubella** vaccine. Serologic confirmation of immunity to rubella is acceptable.
- c. **Students born on or after January 1, 1957, must show, prior to patient contact, acceptable evidence of vaccination of one dose of mumps vaccine. Serologic confirmation of immunity to mumps is acceptable.**

**Measles:** \_\_\_\_\_ **Mumps:** \_\_\_\_\_ **Rubella:** \_\_\_\_\_  
**2<sup>nd</sup> Date:** \_\_\_\_\_

### HEPATITIS B VACCINE

The student should be aware that there is potential of exposure to Hepatitis B during clinical assignments. Students must receive a complete series of hepatitis B vaccine prior to the start of direct patient care or show serologic confirmation of immunity to hepatitis B virus.

**VACCINE**

	Dose #1	Dose #2	Dose #3
Date			

**Administered by:** \_\_\_\_\_  
Signature

Varicella: Students must receive two doses of varicella vaccine unless the first dose was received prior to thirteen years of age. Serologic confirmation of immunity to varicella is acceptable. A parent or physician validated history of varicella disease (chickenpox) or varicella immunity is acceptable in lieu of vaccine. A written statement from a physician, or the student's parent or guardian, must support history of varicella disease.

Dose #1: Date & Administered by	Dose #2: Date & Administered by

**Physician or Nurse Practitioner's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician or Nurse Practitioner's Printed Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_ **Telephone Number:** \_\_\_\_\_