McLennan Community College

IMMUNIZATION RECORD FOR HEALTH CAREERS STUDENTS

NAME OF STUDENT:_____ **Student ID #**_____
(print)

T.B. Test (Annual Update Required)
Must Be IRGA Serum Blood Screening

T-Spot: Date _____ Results _____
or
Quantiferon Gold: Date_____Results_____

Chest X-ray: Date _____ Results _____
(Chest X-Ray within 90 days of start date)

IMMUNIZATIONS:
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:_____

HEPATITIS B VACCINE

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. (If receiving the Heplisav hepatitis B vaccine, it must be specifically notated)

	Dose #1	Dose #2	Dose #3
Date			

Varicella: Students must receive two doses of varicella vaccine.
Serologic confirmation of immunity to varicella is acceptable.
A parent or physician validated history of varicella disease (chickenpox) or varicella immunity is NOT acceptable

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

Seasonal flu vaccination: Date: _____

Covid Vaccine: Students must receive one dose of Johnson & Johnson or two doses of Moderna or Pfizer vaccine.

Dose #1: Vaccine Manufacturer & Date	Dose #2: Vaccine Manufacturer & Date

Physician or Nurse Practitioner's Signature: _____ Date: _____

Physician or Nurse Practitioner's Printed Name: _____

Address: _____ Telephone Number: _____

Revised 2023