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		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Mumps		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Rubella		☐ Immune ☐ Non-Immune ☐ Equivocal	**OR**	X 2	(Dose 1 must be on or after age one)	
Varicella		☐ Immune ☐ Non-Immune ☐ 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				☐ Adacel ☐ Boostrix ☐ __________
		Healthcare Professional Students **(DGSOM, Dental, Nursing, Social Welfare)** ONE DOSE IN THE LAST 10 YEARS				☐ Adacel ☐ Boostrix ☐ __________

Vaccination	Date received	Manufacturer	Lot #		Declination
Seasonal Influenza	(Doe mut e on or a er uut , of enterin hoo year)			OR	☐ 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		☐ Reactive ☐ Non-Reactive	3 dose series (Engerix-B or Recombivax) Or 2 dose series (Heplisav-B)		☐ Engerix-B ☐ Recombivax ☐ Heplisav-B
					☐ Engerix-B ☐ Recombivax ☐ Heplisav-B
					☐ Engerix-B ☐ Recombivax ☐ Heplisav-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: ☐ Negative ☐ Positive*
OR				
Quantiferon or T-spot (Interferon Gamma Release Assay – IGRA) ***Required for Healthcare Professional Students or students with a history of BCG Vaccine.***	Date of test: (MM/DD/YYYY)	Name of test: ☐ Quantiferon ☐ T-Spot	Result: ☐ Negative ☐ Positive* ☐ 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: ☐ Negative ☐ 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):