nscc
School of Health & Human Services

IMMUNIZATION FORM

RETURN FORM TO ACADEMIC CHAIR'S OFFICE

Student Name: _____

Student Program: _____

Date of Birth: _____

Student ID: _____

A health care professional such as a doctor or nurse must complete and sign this form for you and indicate that all immunization requirements listed below are current.

It is recommended you retain a photocopy of this form for future employers. Students will be notified by the campus if requirements change or additional requirements are added. Please make sure to attach any supporting documentation.

Immunizations	Date Vaccine Given / Serology Results			Initials of Health Care Provider
Diptheria/Tetanus/Pertussis (dTap) *Booster in past 10 years*				
Measles/Mumps/Rubella (MMR) *Two doses required if born after 1970*	#1			
	#2			
Varicella – History of Chicken Pox (*Provide proof of one, regardless of year of birth*)	Dose 1: Dose 2:			
	Immune: Confirmed Varicella:			
Hepatitis B** *Please note- If non- immune, documented evidence of first dose is required and it will be necessary for you to sign a waiver prior to your first practicum/placement.* *Exceptions: Cosmetology; Esthetics and Spa Therapies, Community Recreation, Health Information Management*	Dose 1:			
	Dose 2:			
	Dose 3:			
	Immune Non-immune			
Tuberculosis Skin Test (TST) Two Step *TB Testing is required once every two years for the following programs:* *Disability Supports & Services, Continuing Care, Dental Assisting Level II, Health Information Management, Medical Laboratory Technology, Mental Health Recovery and Promotion, Occupational Therapy/Physiotherapy Assistant, Therapeutic Recreation, Pharmacy Technician, Practical Nursing*	Date Given: 1st Step: 2nd Step:	Date Read:	Result: mm	

Health Care Professional (Doctor, Nurse, Pharmacist) who has reviewed supporting documentation & administered any outstanding vaccinations / tests as required:

Name (Please Print):_____ Title: _____

Signature: _____ Date: _____