

## IMMUNIZATION AND LAB TESTS ATTESTATION

Before working in a health setting, there are specific immunizations and lab tests that are required for the safety of patients and the protection of your health.

Enrollee Name (print): \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

**This form must be signed by a Healthcare Provider.**

	Date Administered	Date Read	Results
2 –Step TB Skin Test #1 (PPD)	PPD #1: ____/____/____	____/____/____	____mm
2 –Step TB Skin Test #2 (PPD) (one week or more after PPD #1 result is read)	PPD #2: ____/____/____	____/____/____	____mm
Hepatitis B (3 dose series): <ul style="list-style-type: none"> <li>Hepatitis B Titer is also acceptable. It must be (+). (Please submit laboratory evidence)</li> <li>Hep B Declination also accepted. (Must submit signed declination form.)</li> </ul> <p><i>Note: All students who have not completed the Hep B Series must sign declination form.</i></p>	1 <sup>st</sup> Injection: ____/____/____  2 <sup>nd</sup> Injection: ____/____/____  3 <sup>rd</sup> Injection: ____/____/____		
Tetanus –Diphtheria – Pertussis (Tdap). Must have received one since 2005, and 1 Td booster every 10 years thereafter.	Tdap: ____/____/____ (one since 2005)		
	Td: ____/____/____ (if applicable)		
<b>*Titers required with laboratory evidence:</b> <ul style="list-style-type: none"> <li>Varicella</li> <li>Measles</li> <li>Mumps</li> <li>Rubella</li> <li>Hepatitis B* (if unable to provide proof of immunization, Declination Form also accepted)</li> </ul>			

\_\_\_\_\_  
Signature of Physician or Nurse Practitioner

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Physician or Nurse Practitioner

\_\_\_\_\_  
Address