

**UNIVERSITY OF NORTH CAROLINA HEALTH CARE VACCINATION VERIFICATION FORM**

Legal Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR PERSONAL PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT. LIP SIGNATURE REQUIRED.**

TUBERCULOSIS SCREENING				
TB Skin Test (TST) - 2 step history (2 TB skin tests placed at least 1 week apart but within 1 year) with at least one test in the last 12 months.		<i>Step 1</i>	<i>Step 2</i>	<i>Annual</i>
	Date Placed:			
	Date Read:			
	Induration (mm):			
	Result (Pos/Neg.):			
IGRA (T-Spot, Quantiferon Gold, etc.)	Date:			
	Result:			
Chest x-ray - in the last two years with documentation of official report.	Date:			

REQUIRED IMMUNIZATIONS					
	Vaccinations			Titer(s)	
Tdap (One vaccine as an adult or child).	(#1)				
MMR Two MMR vaccinations at least 1 month apart given after age 1. ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination.	(#1)	(#2)	Titer positive date: Measles	Titer positive date: Mumps	Titer positive date: Rubella
Varicella (chicken pox) Series of two doses or immunity by positive blood titer.	(#1)	(#2)	Titer Positive date:		
Flu Vaccine (annually)	(#1)				

RECOMMENDED IMMUNIZATIONS				
	Vaccinations			Titer
	mo/day/year	mo/day/year	mo/day/year	Titer Date/Result
Hepatitis B Vaccine (Hepatitis B vaccine is a 3 vaccine series that is completed at intervals recommended by the CDC. If a negative HBsAB is found after a completed first series, a second series may be indicated. If a second negative HBsAB is resulted after a completed second series, diagnosis of non-responder.)	<i>1<sup>st</sup> Series</i>			
	(#1)	(#2)	(#3)	Titer
	<i>2<sup>nd</sup> Series (if given)</i>			
	(#1)	(#2)	(#3)	Titer

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Signature of Physician/Nurse Practitioner/Physician Assistant \_\_\_\_\_ Date \_\_\_\_\_

Printed name of Physician/Nurse Practitioner/Physician Assistant \_\_\_\_\_ Phone number \_\_\_\_\_

Office Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_