|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|   |   |   |   |   |
| Last Name |  | First Name |  | MI | Sex | Date of Birth |
|  |  |  |  |  |  |  |
|   |   |   |   |
| Social Security Number | Cell Phone | Home Telephone | Work Telephone |
|  |  |  |  |  |  |  |
|   |   |   |   |
| Mailing Address: Street |  |  | City |  | State | Zip |
|   |   |   |   |   |   |   |
|  |  |  |  |  |  |  |
|  |
|  |  |
| **PHYSICAL/VITAL SIGNS** | **TUBERCULOSIS (TB)** |
| Good for 1 Year | **1st Step ↓** | Good for 1 Year |  **2nd Step ↓** |
|   |   | *Read in 48 - 72 Hours* |   | *Applied 7-21 days after 1st Step* |
| Temperature |   |   | Date Applied |   |
|   |   |   | Site |   |
| Pulse |   |   | Signature |   |
|   |   |   | Lot # |   |
| Respiratory Rate |   |   | Date Read |   |
|   |   |   | Signature |   |
| Blood Pressure |   |   | Results (mm) |   |
|  |  |  |  |  |  |  |
|  |  | *A positive TB result with the two-step Mantoux test necessitates a Chest X-ray* |
| Chest X-ray: (Attach a copy of the report) | Date: |   | Results: |   |   |
|  |  |  |  |  |  |  |
| **IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE STUDENT IS FREE FROM ACTIVE TUBERCULOSIS DISEASE** |
|   |   |   |   |   |   |   |
|   |   |   |   |   |   |   |
| **IMMUNIZATION HISTORY** |  |
|  |  |  |  |  |  |  |
|  |  | Enter Month, Day and Year Each Immunization was Given: |
|  |  |  |  |  |  |  |
| **VACCINE(S)** | **DOSES** | **BOOSTERS & DATES** |
| **Tetanus**  (Must be within the last 10 years) | 1 | 2 | 3 | 4 | 5 |
| **Hepatitis B**  (Series of 3 injections over 6 months) | 1 | 2 | 3 |   |   |
|   |   | (Today) | (1 Month Later) | (6 Months Later) |   |   |
| **MMR** (Measles, Mumps, Rubella) |   | 1 | 2 |   |   |   |
|   |   |   |   |   |   |   |
|  |  |  |  |  |  |   |
| I certify that the above record is true according to produced medical |  The statements and answers as recorded are full, complete and true |
| records, physical examinations and/or laboratory confirmation. |  to the best of my knowledge and belief. |   |
|   |   |   |   |   |  |   |
| **Physician/Facility** |   | **Date:** | **Student**  |   |   | **Date:** |
| **Signature/Stamp:** |   |   | **Signature:** |   |   |   |