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 after the 1st one is read, but within 1 year). Test must not be more than 12 months older than the start date in the academic program.		*Step 1*	*Step 2*	*Annual*
	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 ≥ 11 years of age)	(#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	*1st Series*			

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.)	(#1)	(#2)	(#3)	Titer
	2nd Series (if given)			
	(#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