



CARILION IMMUNIZATION RECORD

Section I: To be completed by applicant *Applicants MUST have had all the immunizations listed below.*

Printed Name:	
Date of Birth (MM/DD/YY):	School-Provided E-mail Address:
Rotation Start Date (MM/DD/YY):	

Section II: To be completed by approved School Representative or Health Care Provider
(NO OTHER IMMUNIZATION FORMS are accepted. Instead summarize immunizations below.)

	Check appropriate circle.	Yes	No
<ul style="list-style-type: none"> • MMR <i>Two Doses of MMR Vaccine</i> (The 1st vaccination was received on or after the first birthday and the 2nd vaccination was received at least 28 days after the first dose.) ----- <i>Alternative Regimen</i> 1. Measles (Rubeola): Two Vaccines are required or Positive Serology (The 1st vaccination was received on or after the first birthday and the 2nd vaccination was received at least 28 days after the first dose.) 2. Mumps : One dose of Vaccine on or after 1st birthday or Positive Serology 3. Rubella: One dose of Vaccine on or after 1st birthday or Positive Serology 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<ul style="list-style-type: none"> • Tuberculosis (Initial and yearly tests more than 4 months out of date must be the 2-Step Test.) Negative results dated within 12 months of rotation dates in Section I above. ----- If No above, negative results required on chest x-ray 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Varicella ~ <i>Vaccines or positive serology or had disease</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Polio ~ <i>Primary series of Vaccine</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Tetanus-Diphtheria ~ <i>Primary series of Td immunizations and a Td or Tdap booster dose administered within 10 year of coming to Carilion</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
• Hepatitis B ~ <i>Vaccines or Positive Serology</i>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<ul style="list-style-type: none"> • Influenza (The CDC requires us to report the following information.) <i>Most recent vaccination is dated (MM/DD/YY) _____.</i> <i>Most recent vaccination will be effective through rotation dates listed in Section I above.</i> <i>The school requires that students receive vaccinations between October 1st and March 31st.</i> ----- <i>Student refused vaccination for reasons other than medical contraindication.</i> <i>Student refused vaccination for medical contraindication related to _____.</i> 	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Signature of Approved School Representative or Health Official Completing This Form		Date (MM/DD/YY)
Printed Name	Title	Phone
Name of School or Health Care Provider's Address	School Seal (Optional for Health Care Provider)	