Immunizations and Tests
Required by State Law/Clinical Facilities

Name: ______________________________ **Date of Birth:** ____________________

Program: ______________________________ **FPC ID#:** ______________________________

Measles (Rubeola): Those born on or after January 1, 1957, must show proof of either:	
A. Two doses of measles vaccine on or after their first birthday and at least 30 days apart **OR** ***See note.**	Date #1 ____________ Date #2 ____________ (mm/dd/yy) (mm/dd/yy)
B. Record of physician-diagnosed measles **OR** ****See note.**	Date ____________ (mm/dd/yy)
C. Serologic test positive for measles antibody ****See note.**	Date ____________ Result (mm/dd/yy)
Mumps: Those born on or after January 1, 1957, must show proof of either:	
A. One dose of mumps vaccine on or after their first birthday **OR**	Date ____________ (mm/dd/yy)
B. Record of physician-diagnosed mumps **OR** ****See note.**	Date ____________ (mm/dd/yy)
C. Serologic test positive for mumps antibody ****See note.**	Date ____________ Result (mm/dd/yy)
Rubella: Those born on or after January 1, 1957, must show proof of either:	
A. One dose of Rubella vaccine on or after their first birthday **OR**	Date ____________ (mm/dd/yy)
B. Record of physician-diagnosed Rubella **OR** ****See note.**	Date ____________ (mm/dd/yy)

C. Serologic test positive for Rubella antibody ****See note.**	Date ____________ Result ____________ (mm/dd/yy)

***Combined MMR Vaccine is vaccine of choice if recipients are likely to be susceptible.**
****Must be the date of diagnosis or test collection; not when primary care provider signed immunization form.**
+Vaccines administered after September 1, 1991 shall include the MM/DD/YY each vaccine was given.

Hepatitis B must show proof of:	
A. Three doses of vaccine administered over a period of 4 to 6 months **OR There is a 4 month accelerated series approved by the CDC and TDHS. Administer vaccine at 1st month, 2nd month, & 4th month.**	Date #1 ____________ (mm/dd/yy) Date #2 ____________ (mm/dd/yy) Date #3 ____________ (mm/dd/yy)
B. Serologic test positive for Hepatitis B antibody ****See note.**	Date ____________ Result ____________ (mm/dd/yy)

Varicella must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart **OR**	Date #1 ____________ (mm/dd/yy) Date #2 ____________ (mm/dd/yy)
B. Serologic test positive for Varicella antibody **OR** ****See note.**	Date ____________ Results ____________ (mm/dd/yy)
C. Physician documented history of diagnosis of Varicella ****See note.**	Date Disease Occurred ____________ (mm/dd/yy)

Diphtheria, Tetanus (TDAP): One dose within past 10 years	Date ____________ (mm/dd/yy)
Meningococcal	Date ____________ (mm/dd/yy)

Tuberculin Test (PPD):	Date Administered ____________ Date Read: ____________

Must be performed annually *Or copy of chest x-ray report if reactive PPD	Results: ______________ Test Read By: __________________

Primary Care Provider Information:	
Printed Name	
Address	
Signature of Primary Care Provider	Date

Original form <u>must be returned to the Vocational Nursing Department</u>!!!
Reviewed 1/2017