HEALTH IMMUNIZATION FORM
Western Technical College (revised Feb 2018)

- **THIS FORM MUST BE SIGNED BY A HEALTHCARE PROFESSIONAL (PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, NURSE OR MEDICAL ASSISTANT).**
- **NURSING ASSISTANT STUDENTS ARE ONLY REQUIRED TO COMPLETE THE TUBERCULOSIS (TB) SKIN TEST.**
- **All other health/education programs are required to complete the entire form. Understand that the clinical sites or other agencies may require additional immunizations or titers. You will be contacted if this applies to your placement**.

Western uses the current Center for Disease Control and Prevention (CDC) guidelines to determine the acceptability of documentation for proof of immunization.

PATIENT INFORMATION

NAME_____ DATE OF BIRTH _____PROGRAM_____

MMR VACCINE
(MEASLES (RUBEOLA) / MUMPS / RUBELLA)

Date of Vaccines #1_____

#2_____

OR

Dates of Titer

Measles (Rubeola) Titer _____
Immune / Non-Immune

Mumps Titer _____
Immune / Non-Immune

Rubella Titer_____
Immune / Non-Immune

If born before 1957:

a) Proof of immunity for Measles, Mumps & Rubella via documentation of disease in medical record or titres
b) 2 doses of vaccine to satisfy requirements for Measles; 2 doses of vaccine to satisfy requirements for Mumps; 1 dose of vaccine to satisfy requirement for Rubella

TB SKIN TEST (required annually)

Two consecutive annual tests between 10 and 12 months apart. Please note that the second test *must not exceed 365 days from when the last one was administered*.

Current Year Read Date: _____ Initials _____
Negative / Positive

Previous Year Read Date: _____ Initials_____
Negative / Positive

If you do not have 2 consecutive current skin tests, a two-step is needed. ***Test dates must be 7-21 days apart.***

Step 1 Test Date: _____ Read Date_____

Step 1 Results:_____Negative/Positive _____Initials

Step 2 Test Date:_____ Read Date_____

Step 2 Results: _____Negative/Positive _____Initials

If you have a positive TB test or have a documented history of a positive TB test:

- *A negative chest x-ray report must be provided*
- *You must provide annual documentation that you are fee of communicable disease*
- *Contact Enrollment Services at 608.789.6138 for special instructions*

If your chest x-ray is positive for TB, proof of treatment is required.

_____ _____

Signature of Healthcare Provider **Printed Name and Title** **Date**

SUBMIT ALL DOCUMENTATION TO: Western Technical College, Enrollment Services-Student Immunization Records,
400 Seventh Street North, PO Box C-0908, La Crosse WI 54602-0908
Fax 608-785-9148For questions ca11608-785-9200 or 1-800-322-9982, ext.59553

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TO THE STUDENT:
All programs have affiliation agreements with agencies which require verification of compliance with the employee health standards. In many programs, these experiences begin within the first two weeks of school.

The form (BOTH SIDES) must be filled out completely.

PLEASE KEEP A COPY OF THIS RECORD FOR YOUR FILES.

Name_____

(Previous Name)_____

Address_____

_____

Student ID or SS # _____

Program Title _____

Date of Birth _____

Phone (Day) _____(eve)_____

HEPATITIS B VACCINE

Date of Vaccines

#1_____ #2_____ #3_____

OR

Hepatitis B Titer_____ Immune / Non-Immune
(*Attach copies of lab results*) (Circle one)

OR

Signed Declination Statement below:

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I decline the vaccination at this time. I understand that by declining the Hepatitis B vaccine I continue to be at risk of acquiring Hepatitis B as a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at that time.

_____
Student Signature Date

VARICELLA (CHICKEN POX)

Date of Vaccines #1_____ #2_____

OR

Varicella Titer _____ Immune / Non-Immune
(*Attach copies of lab results*) (Circle one)

OR

Verified history of Chicken Pox Disease

If yes, Date: _____

TETANUS / DIPHTHERIA (TD)

OR

TETANUS,DIPHTHERIA,ACCELLULAR PERTUSSIS (TDaP)

TD or TDaP is required every 10 years

Date _____ TD / TDaP (circle one)

_____
Signature of Healthcare Provider

_____
Printed Name and Title Date

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