Certification of Immunizations

NAME: Last:_____   First:_____   Middle Initial:_____

REQUIRED IMMUNIZATION INFORMATION:

Vaccine	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	Lab Result/Date
MMR			/////////////////	Result:
Varicella			/////////////////	Result:
Tdap /Tetanus-Diphtheria-Pertussis		/////////////////	/////////////////	/////////////////
Td – Tetanus Booster		/////////////////	/////////////////	/////////////////
Influenza		/////////////////	/////////////////	/////////////////
COVID			/////////////////	/////////////////
Hepatitis B				Result:
TST (Tuberculin Skin Test)	Result:_____mm Placed: Read:	Result:_____mm Placed: Read:	Result:_____mm Placed: Read:	/////////////////

MMR – two doses or positive lab result required

Varicella - two doses or positive lab result required

Tdap - One adult dose of Tdap required, thereafter Tetanus Diphtheria (Td) booster every 10 years.

Influenza - required annually, September through May

COVID – VOLUNTARY Annotate **Manufacturer** and date of two vaccinations

Hepatitis B Series - Series of 3 doses required at 0, 1, and 6 months or positive lab result.

TST-

- Must have 2 negative TSTs within the last year and the most recent one **within 90 days of training**. Provide both results. **OR**
- Two or more previous documented negative TSTs greater than 12 months old, a single TST within **90 days** of training is required. Provide all three results. **OR**
- For positive TST history, a negative chest x-ray report and a physician statement indicating absence of active tuberculosis disease is required.

CERTIFICATION OF A HEALTH CARE PROVIDER (This information is required)

Mandatory Office or Healthcare Provider Stamp

Name:_____   Signature:_____

Office Address: _____

Phone:_____   Date:_____