

HEALTH RECORD VERIFICATION

NAME: _____

INSTRUCTIONS: Written documentation showing compliance with immunization and tuberculosis screening is required prior to a student internship. An official record of immunizations (pink book) or laboratory results from a health care provider are required for verification of immunity.

MEASLES, MUMPS, ,RUBELLA (MMR) Immune status must be confirmed by:

2 - MMR immunizations after the first birthday. Dates: #1 _____ #2 _____

NOTE: If the student has not had 2 MMRs after the first birthday, please notify the Staff Development Coordinator at Salina Regional Health Center.

CHICKENPOX: Immune status must be confirmed by one of the following.

____ Varicella vaccine (documentation required): Date #1: _____ Date #2: _____

____ Varicella titer (documentation required) Date: Results: _____

HEPATITIS B SERIES: Not currently required.

Health, dental, and emergency care personnel are among the highest groups at risk of becoming infected with Hepatitis B; therefore, routine vaccination is required of health care providers. Some organizations may ask for verification of Hepatitis B vaccination **OR** require vaccination prior to a student internship. **The vaccination involves three injections over six months;** this course needs to be completed for maximum protection. **Please indicate whether or not you have previously completed Hepatitis B vaccination.**

Hepatitis B vaccination series: Date of injections #1 _____ #2 _____ #3 _____

INFLUENZA VACCINE: Observations and clinicals between the dates of November 1 and April 1 need a current influenza vaccine or will wear a mask for each patient encounter.

Date: _____

COVID 19 Vaccine: Please attach proof of complete vaccination.

VERIFICATION BY A HEALTH PROFESSIONAL IS REQUIRED

Immunizations must be verified by a **school nurse, doctor, Health Department, etc.** The person verifying **CANNOT** be the same as the name at the top of the form.

Verified by: _____ Date: _____

School/Agency: _____

TUBERCULOSIS: A tuberculin skin test is required within the last 12 months.

Date: _____ Results: _____

VERIFICATION BY A HEALTH PROFESSIONAL IS REQUIRED

Immunizations must be verified by a **school nurse, doctor, Health Department, etc.** The person verifying **CANNOT** be the same as the name at the top of this form.

Verified by: _____ Date: _____

School/Agency: _____