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| --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |
|  | |  | |  |  |  |
| Last Name |  | First Name |  | MI | Sex | Date of Birth |
|  |  |  |  |  |  |  |
|  |  | |  | |  | |
| Social Security Number | Cell Phone | | Home Telephone | | Work Telephone | |
|  |  |  |  |  |  |  |
|  | | |  | |  |  |
| Mailing Address: Street |  |  | City |  | State | Zip |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
|  | | | | | | |
|  | |  | | | | |
| **PHYSICAL/VITAL SIGNS** | | **TUBERCULOSIS (TB)** | | | | |
| Good for 1 Year | | **1st Step ↓** | | Good for 1 Year | **2nd Step ↓** | |
|  |  | *Read in 48 - 72 Hours* | |  | *Applied 7-21 days after 1st Step* | |
| Temperature |  |  | | Date Applied |  | |
|  |  |  | | Site |  | |
| Pulse |  |  | | Signature |  | |
|  |  |  | | Lot # |  | |
| Respiratory Rate |  |  | | Date Read |  | |
|  |  |  | | Signature |  | |
| Blood Pressure |  |  | | Results (mm) |  | |
|  |  |  |  |  |  |  |
|  |  | *A positive TB result with the two-step Mantoux test necessitates a Chest X-ray* | | | | |
| Chest X-ray: (Attach a copy of the report) | | Date: |  | Results: |  |  |
|  |  |  |  |  |  |  |
| **IF SIGNIFICANT REACTION WAS REPORTED, THE PHYSICIAN REPORT MUST STATE THAT THE STUDENT IS FREE FROM ACTIVE TUBERCULOSIS DISEASE** | | | | | | |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| **IMMUNIZATION HISTORY** | |  | | | | |
|  |  |  |  |  |  |  |
|  |  | Enter Month, Day and Year Each Immunization was Given: | | | | |
|  |  |  |  |  |  |  |
| **VACCINE(S)** | | **DOSES** | | | **BOOSTERS & DATES** | |
| **Tetanus**  (Must be within the last 10 years) | | 1 | 2 | 3 | 4 | 5 |
| **Hepatitis B**  (Series of 3 injections over 6 months) | | 1 | 2 | 3 |  |  |
|  |  | (Today) | (1 Month Later) | (6 Months Later) |  |  |
| **MMR** (Measles, Mumps, Rubella) |  | 1 | 2 |  |  |  |
|  |  |  |  |  |  |  |
|  |  |  |  |  |  |  |
| I certify that the above record is true according to produced medical | | | The statements and answers as recorded are full, complete and true | | | |
| records, physical examinations and/or laboratory confirmation. | | | to the best of my knowledge and belief. | | |  |
|  |  |  |  |  |  |  |
| **Physician/Facility** |  | **Date:** | **Student** |  |  | **Date:** |
| **Signature/Stamp:** |  |  | **Signature:** |  |  |  |