

**River Valley Community College  
Medical Laboratory Technician  
Immunization Record**

Students ***MUST*** have documentation proving immunity to these infectious diseases ***PRIOR*** to attending any clinical facility associated with their program of study. Please ensure that ***ALL*** components of this form are completed before returning to the PROGRAM director.

**Student Name:** \_\_\_\_\_ **ID Number@** \_\_\_\_\_

	Comments	Date and Type of Vaccine	Results of titer
Measles	MMR Two doses of live vaccine on or after first birthday <b>OR</b> results of titer <b>OR</b> Documentation by physician with diagnosis.		TITER: Date: _____ Does this result indicate immunity? Yes No
Mumps	MMR Two doses of live vaccine on or after first birthday <b>OR</b> of titer <b>OR</b> Documentation by physician with diagnosis.		TITER: Date: _____ Does this result indicate immunity? Yes No
Rubella	MMR One dose of live vaccine on or after first birthday <b>OR</b> Results of titer		TITER: Date: _____ Does this result indicate immunity? Yes No
Polio	Polio		Date: _____
Pertussis/Tetanus	DPT or Td with a booster within 10 years		Documentation of last tetanus or TdaP.
Hepatitis B	3 doses Or <u>signed</u> declination form.	#1. #2. #3.	TITER: Date: _____ Does this result indicate immunity? Yes No
Chickenpox (Varicella)	Varicella Two doses of vaccine <b>OR</b> Documentation by physician with diagnosis <b>OR</b> Varicella titer		Date: _____
TB	PPD/Mantoux test 2 negative TB tests within the year prior to affiliation.		Results of skin test (in mm.) and dates.

Signature of Primary Care Provider

Date

*I agree to the release of this information to the assigned RVCC Program Director and the education clinical coordinator at any agency where I am scheduled for fieldwork, clinical assignment, internships or affiliations. I understand that all HIPPA regulations regarding confidentiality of this information will be followed.*

Signature of Student

Date