MEDICAL IMMUNIZATION FORM FOR MSAD #37 ADULT & COMMUNITY EDUCATION

Dear Health Provider:
The person named below is enrolled in an MSAD #37 Adult & Community Education healthcare training program. Our policy, in conjunction with state and federal guidelines, requires a health statement for the protection of both patients and students. Please complete the following required information on both sides. If you have any questions, please contact Eric Brooks at (207) 483-6681.

I authorize the release of the following information to MSAD #37 Adult & Community Education.

Student Name _____ Signature _____

TO BE COMPLETED BY HEALTHCARE PROVIDER.

Known Allergies: _____

1. **Tetanus/Diptheria/acellular Pertussis (Tdap)** It is recommended that students receive one dose of Tdap. ___/___/___ **OR** at the very least show a record of the last **Tdap** booster: ___/____/___. This Td date must be within the last 10 years. If it is not, students should receive Tdap booster.

2. **TB Test (Subcutaneous PPD/Mantoux)** Either a two-step PPD **OR** an IGRA/TB serology.

PPD #1 date:____/____/____. Read date ____/____/____ Result _____ mm
PPD #2 date:____/____/____. Read date ____/____/____ Result _____ mm
IGRA/TB seriology date drawn: ____/____/____ Result: _____
Note: If the patient has a positive PPD or IGRA result and/or history of tuberculosis, a chest x-ray **must** be done and a copy of the report must accompany this form.

3. **Rubeola (measles)** immunity must be verified by the following: documentation of 2 MMRs OR 2 doses of rubeola vaccine OR physician diagnosed/documented history OR lab documentation of immunity (titer). Copy of documentation should be attached.

MMR 1: _____/_____/_____ MMR 2: _____/_____/_____	OR	Measles Diagnosis: _____/_____/_____	OR	Rubeola Titer: ____/_____/_____ Result:

4. **Mumps** immunity must be verified by the following: Documentation of 2 MMRs OR 2 doses of mumps vaccine OR physician diagnosed/documented history OR lab documentation of immunity (titer). Copy of documentation should be attached.

MMR 1: _____/_____/_____ MMR 2: _____/_____/_____	OR	Mumps Diagnosis: _____/_____/_____	OR	Mumps Titer: ____/_____/_____ Result:

5. **Rubella (German measles)** immunity must be verified by the following: Documentation of 1 MMR OR 1 dose of rubella vaccine OR lab documentation of immunity (titer). Copy of documentation should be attached.

MMR 1: _____/_____/_____	OR	German Measles Diagnosis: _____/_____/_____	OR	Rubella Titer: ____/_____/_____ Result:

6. Varicella (chickenpox) immunity must be verified by the following: Documentation of 2 doses of varicella vaccine OR physician diagnosed/documented history of chickenpox or herpes zoster (shingles) OR lab documentation of immunity (titer).

Varicella 1: ____/_____/_____ Varicella 2: ____/_____/_____	OR	Varicella Diagnosis: _____/_____/_____	OR	Varicella Titer: ____/_____/_____ Result:

7. Hepatitis B vaccine
If the student has received all 3 doses prior to class, then they should provide recent documentation confirming immunity. **HEPBsAb: ___/___/___ and result _____.**

HepB 1:____/____/____ HepB 2: ____/____/____ HepB 3: ____/____/____

8. **COVID-19 vaccine**
Pfizer/Moderna #1: ____/____/____ #2 :____/____/____ J&J :____/____/____

Booster: ____/____/____ Students must be fully vaccinated two weeks prior to start of clincals.

9. **Flu vaccine** (must have current flu season vaccine prior to clinical). **Date: ____/____/____**

10. Are there any psychological or mental limitations/restrictions on the above named person?
Yes____ No ____ If yes please explain below.

11. Is this person physically able to perform his/her duties?
Yes _____ No _____ If no please explain below.

12. Are there any issues that would limit this person from performing duties of a CNA?
Yes_____ No _____ If yes please explain below.

13. Length of time patient has been under the care of the examining physician: _____

Other comments/considerations: _____
_____
_____

_____
Signature **Date** **Name of Health Care Facility**

_____
Print Name & Title

Please send, fax, or email this form to:
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Fax: (207) 484-4589. Email: ebrooks@msad37.org Phone: (207) 483-6681