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.

_____Signature _____ TO BE COMPLETED BY HEALTHCARE PROVIDER.

Known Allergies:

Student Name

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

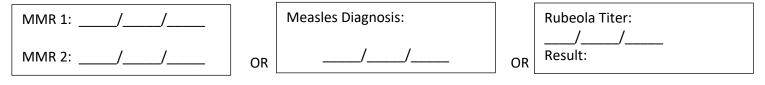
 PPD #1 date:
 /
 . Read date
 /
 . Result
 mm

 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.



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:/		Mumps Diagnosis:		Mumps Titer: //
MMR 2:/	OR	//	OR	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:	//	

German	Measles	Diagnosis:	
German	Wiedbieb	Diagnosis.	

____/___/____

OR

Rubella Titer:
//
Result:

OR

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).

Print Name & Title		ax, or email this form to:		
Signature	Date	Name of Health	Care F	acility
Other comments/considerations	::			
13. Length of time patient has be	een under the care o	of the examining physicia	ו:	
Yes No If yes pleas	e explain below.			
12. Are there any issues that wo	•	from performing duties of	of a CNA	λ?
11. Is this person physically able Yes No If no pleat	•	duties?		
10. Are there any psychological of the second se		s/restrictions on the abov	e name	d person?
9. Flu vaccine (must have curren	t flu season vaccine	prior to clinical). Date:	/	_/
Booster:/ Stude	nts must be fully vac	cinated two weeks prior	to start	of clincals.
8. COVID-19 vaccine Pfizer/Moderna #1://	#2 :/	/ J&J :	_/	/
HepB 1:///	HepB 2:/	/ НерВ 3:/	/	
7. Hepatitis B vaccine If the student has received all 3 Immunity. HEPBsAb://_	•		e recent	t documentation confirming
Varicella 2://	- OR	//	OR	Result:
				//

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