

**Volunteer/International Visitor Immunization Documentation**

Name (print): \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_

**The following information is required in accordance with Thomas Jefferson University Hospital Infection Control Policy.**

**To be filled out by Physician or Nurse Practitioner**

**Chicken Pox/Varicella:** Proof of immunity will mean two doses of varicella, a physician documented history of disease or serologic evidence of immunity

History of Varicella: Yes \_\_\_ No \_\_\_ Date: \_\_\_\_\_

Immunization: Date 1: \_\_\_\_\_ Date 2: \_\_\_\_\_

Titer: Date: \_\_\_\_\_ Result: \_\_\_\_\_ (copy attached)

**Rubella:** Proof of immunity to German Measles will mean one dose of the rubella vaccine or serologic evidence of the disease (attach copy).

Immunization Date: \_\_\_\_\_

Titer: Date: \_\_\_\_\_ Result: \_\_\_\_\_ (copy attached)

**Rubeola:** Proof of immunity to measles will mean two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at least one month, or serologic evidence of immunity.

Immunization Dates: #1: \_\_\_\_\_ # 2: \_\_\_\_\_

Titer: Date: \_\_\_\_\_ Result: \_\_\_\_\_ (copy attached)

**Mumps:** Proof of mumps immunity will mean two doses of mumps vaccine administered on or after the first birthday or serologic evidence of immunity.

Immunization Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_

Titer Date: \_\_\_\_\_ Results: \_\_\_\_\_ (copy attached)

**Tuberculosis Screen:**

\_\_\_ positive history Chest x-ray: \_\_\_\_\_ (report attached – must be within previous 6 months)

\_\_\_ negative history (please document PPD placement below – must be placed within previous 3 months)

**PPD Placement Date:** \_\_\_\_\_ **R arm L arm** **Reading Date:** \_\_\_\_\_ **Result:** \_\_\_\_\_ mm

**If a reaction of > 10mm is documented, you must provide the report of a chest x-ray done after the PPD.**

**Recommended only:**

**Pertussis:** Proof of immunity will mean documentation of the Tdap vaccine (tetanus, diphtheria, pertussis or ADACEL)

Immunization Date: \_\_\_\_\_ (must be post 2005)

**MD/CRNP:** \_\_\_\_\_ (signature) **Phone #:** ( ) \_\_\_\_\_

**Address:** \_\_\_\_\_