*** * FOR CERTIFICATION PURPOSES ONLY * ***

University of Connecticut Health Center
Department of Medicine, Division of Occupational and Environmental Medicine
Employee Health Service - Incoming Graduate Student Information
IMMUNIZATION DOCUMENTATION / SCREENING FORM

First Name____________________ Last Name____________________
Address:____
Soc.Security#__________ T00#__________ Date of Birth__________
Status *(circle)* Medical Resident Volunteer High School Minority Program Student
Dental Resident UCONN Employee Other - EmployeeUCONN Student
Study Program (if student) *(circle)* Medicine(MD) Dental(DMD) **MPH MS PhD Grad School**
Law Social Work Paramedic
Starting Year / class (if student) 2009 yr.

MEASLES: (Must have had 2 doses of MMR- one after 1980 AND positive titer for Measles)
Date of 1st vaccination______/______/______ Date of 2nd vaccination______/______/______
Date of Measles titer______/______/______ Result of titer *(circle)* Immune Not immune
Date of Mumps titer______/______/______ Result of Titer (circle) Immune Not immune
Immunization against religious beliefs? *(circle)* Yes No

RUBELLA: (Must have had one documented dose of MMR AND positive titer for Rubella)
Date of vaccination______/______/______
Date of Rubella titer______/______/______ Result of titer *(circle)* Immune Not immune
Immunization against religious beliefs? *(circle)* Yes No

VARICELLA: (Verbal history of positive disease in the past AND positive titer for Varicella- "chickenpox")
Verbal history of illness. *(circle)* Yes No
Date of Varicella titer______/______/______ Result of titer *(circle)* Immune Not immune

TETANUS DIPHTHERIA or Tdap (Booster recommended every 10 years after initial series)
Date of last vaccine:______/______/______ Date of last booster dose______/______/______

TUBERCULOSIS: (MUST HAVE 2 NEGATIVE TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS)
Type PPD__________ Date planted______/______/______
Result *(circle)* Positive Negative Corresponding size__________
NOTE: If positive PPD, Chest x-ray result must be within 12 months.
Chest x-ray date ______/______/______ Result *(circle)* Positive Negative

HEPATITIS B: (Mandatory 3 doses AND titer after the 3rd dose before starting clinical rotations or lab under BBP OSHA standard)
Naturally Immune? *(circle)* Yes No Previously vaccinated *(circle)* Yes No
Vaccination Dates: 1st Dose______/______/______ 4th Dose______/______/______
(if known) 2nd Dose______/______/______ 5th Dose______/______/______
3rd Dose______/______/______ 6th Dose______/______/______
Titer 1 Date______/______/______ Titer 2 Date______/______/______
Titer Result *(circle)* Positive Negative Titer Result *(circle)* Positive Negative

The documentation above was completed by:

____________________ ____________ ____________________
Name of Health Care Provider *(print)* Telephone Number Address

____________________ ____________
Signature of Health Care Provider Date

PLEASE RETURN FORM TO: UCONN Health Center, Division of Occupational and Environmental Medicine, Employee Health Service, 270 Farmington Avenue, Suite 262, Farmington, CT 06030-6210

Entered by:________Date:________

*** * FOR CERTIFICATION PURPOSES ONLY * ***

University of Connecticut Health Center
Department of Medicine, Division of Occupational and Environmental Medicine
Employee Health Service

IMMUNIZATION CONSENT / DECLINATION FORM

First Name________________________ Last Name________________________
Address:____
Soc.Security#______________ T00#______________ Date of Birth______________

Status *(circle)* Resident / UCONN Student / Volunteer / UCONN Employee / High School Minority Program Student / Other - Employee

Study Program (if student) *(circle)* Medicine(MD) / Law / Dental(DMD) / Social Work / **MPH** / Paramedic / **MS** / **PhD** / **Grad School**

Year of Graduation / class (if student)__**2009**____yr.

CONSENT

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine checked above be given to me or to the person named below for whom I am authorized to make this request.

Type of Vaccine: ***(circle)*** **Varicella** **MMR** **Td/Tdap** **Varicella**

______________________ ______________ ______________
Patient or Legal Guardian Signature Relationship Date

Type of Vaccine *(circle)*: MMR

Date__________Lot#________ ExpDate__________ Site________ Provider____________________

Date__________Lot#________ ExpDate__________ Site________ Provider____________________

Type of Vaccine: Td/Tdap

Date__________Lot#________ ExpDate__________ Site________ Provider____________________

Type of Vaccine: Varicella

Date__________Lot#________ ExpDate__________ Site________ Provider____________________

Date__________Lot#________ ExpDate__________ Site________ Provider____________________

DECLINATION

I understand the information provided and explained to me on the Vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine: ***(circle)*** **MMR** **Td/Tdap** **Varicella**

______________________ ______________ ______________
Patient or Legal Guardian Signature Relationship Date

Reason for Declination:____

SEE REVERSE SIDE