University of Connecticut
Health Center
UCONN Medical Group
Occupational Medicine Clinic
Employee Health Service

(Patient Identification)

IMMUNIZATION DOCUMENTATION FORM

First Name________________________Last Name________________________Date of Birth ____________

Employee	**Resident**	**Student**	**Grad Student**	**Volunteer**
Department:	Medical	Medical	MPH	Adult
____________________	Dental	Dental	PhD	Youth
Job Title:	Start Yr._____	Start Yr._____	**Post-Doctorate**	Summer
____________________				

MMR TITERS ARE REQUIRED
Date of Measles titer _____/_____/_____ Immune Not immune
Date of Mumps titer _____/_____/_____ Immune Not immune
Date of Rubella titer _____/_____/_____ Immune Not immune

MMR VACCINATIONS
1st vaccination _____/_____/_____
2nd vaccination _____/_____/_____

VARICELLA TITER REQUIRED
Date of Varicella titer _____/_____/_____ Immune Not immune
Verbal History of illness: (*circle*) YES NO

VARICELLA VACCINATIONS
1st vaccination _____/_____/_____
2nd vaccination _____/_____/_____

Tetanus diphtheria (Td)
Date of last booster dose _____/_____/_____

Tetanus diphtheria accellular pertussis (Tdap)
Date of vaccine _____/_____/_____

TUBERCULOSIS: 2 TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS REQUIRED
Type PPD 1st _____/_____/_____ PPD 2nd _____/_____/_____
Result *(circle)* Positive (mm) Negative Positive (mm) Negative
If positive PPD, Chest x-ray must be within 12 months.
Chest x-ray date _____/_____/_____
Results (*circle*) Negative Positive
BCG History: (*circle*) YES NO

Quantiferon TB Gold -Date _____/_____/_____
Results ________________________________

HEPATITIS B VACCINATIONS Titer Post Vaccination Required (Not required for Volunteers)
Naturally Immune? *(circle)* Yes No
Previously vaccinated *(circle)* Yes No Unknown
1st Dose _____/_____/_____
2nd Dose _____/_____/_____
3rd Dose _____/_____/_____
Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative
4th Dose _____/_____/_____
5th Dose _____/_____/_____
6th Dose _____/_____/_____
Titer Date _____/_____/_____
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/Time ____________

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT, OR SEND OR FAX TO:
UCONN HEALTH CENTER, SECTION OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE, MEDICAL RECORDS, 263 FARMINGTON AVENUE, FARMINGTON, CT 06030-6210
Fax# 860-679-4587 ***Telephone#*** 860-679-2893

HCH1544

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IMMUNIZATION CONSENT / DECLINATION

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

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.

_______________________________________ _____________________ __________________

Patient or Legal Guardian Signature Relationship Date/Time

Type of Vaccine: MMR (0.5ml subcutaneous)

#1 Date/Time_____________ Manufacturer: ___________________Lot#_____________ Exp__________Site ________________

Provider _____________________________ VIS Edition Date__________________

#2 Date/Time_____________ Manufacturer: ___________________Lot#_____________ Exp__________Site ________________

Provider _____________________________ VIS Edition Date__________________

Type of Vaccine: Tdap / Td (0.5ml intramuscular)

Date/Time_____________ Manufacturer: ___________________Lot#_____________ Exp__________Site ________________

Provider ______________________________ VIS Edition Date______________________

Type of Vaccine: Varicella (0.5ml subcutaneous)

#1 Date/Time_____________ Manufacturer: ___________________Lot#_____________ Exp__________Site ________________

Provider ______________________________ VIS Edition Date______________________

#2 Date/Time_____________ Manufacturer: ___________________Lot#_____________ Exp__________Site ________________

Provider ______________________________ VIS Edition Date______________________

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 Varicella Tdap Td**

________________________________ ______________________ ______________________

Patient or Legal Guardian Signature Relationship Date/Time

Reason for Declination:____