Wallace Community College–Emergency Medical Services

HEALTH RECORD FORM

Name:____**Student ID #:**_______________________

Address:____**Contact Number:**____________________

Emergency Contact Person:____________________________**Contact Number:**______________

INSTRUCTIONS: A physician, nurse practitioner, or physician's assistant must complete and sign this form. Copies documenting Tdap vaccination (and booster if applicable), TB and/or chest x-ray, and lab results must accompany this form *when* submitted to *EMS Program personnel.*

Requirements	
Tetanus Vaccine (tetanus, diphtheria, pertussis) *All students must have a documented Tdap vaccine.*	**Date Administered:** ____ - ____ - ____
Td or Tdap Booster *Only applicable if above Tdap vaccine is older than ten (10) years. Adult Tdap must be followed by Td booster every ten years thereafter.*	**Date Administered:** ____ - ____ - ____ **OR** **Not Applicable** ________ (physician's initials)
MMRV Titers ***Titer results are required***. Vaccination records will not be accepted in place of titer results	**Date(s) Drawn / Results:** **Measles** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Mumps** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Rubella** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal **Varicella** ____ - ____ - ____ / □ Immune □ Not Immune □ Equivocal
Hepatitis B Titer ***Titer results are required****. Vaccination records will not be accepted in place of titer results.*	**Date Drawn / Results:** ____ - ____ - ____ / □ Immune □ Not Immune
2-step TB Skin Test or Chest X-ray *Results from the two-step TB skin tests* ***cannot be more than four (4) weeks apart****. Results are valid for one year. A one-step TB update will be required thereafter.* ***Students who have tested positive for TB or who are unable to receive the TB skin test must submit narrative documentation of a clear chest x-ray. Documentation of reason for chest x-ray instead of serum is required.***	**1st Step** Lot # ________ Manuf. ________ Exp. Date ________ Time Applied ________ Reader Signature ______________ Date Administered: ____ - ____ - ____ Date Read: ____ - ____ - ____ Result: _____ mm of induration Interpretation: □ Positive □ Negative **2nd Step** Lot # ________ Manuf. ________ Exp. Date ________ Time Applied ________ Reader Signature ________________ Date Administered: ____ - ____ - ____ Date Read: ____ - ____ - ____ Result: _____ mm of induration Interpretation: □ Positive □ Negative **OR** **Chest X-Ray** Date of CXR: ____ - ____ - ____ / Result: □ Normal □ Abnormal

Healthcare Provider Signature Required: I have reviewed this student's immunization status and have made recommendations regarding any follow-up related to safe practice as a health care provider.

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Physician, PA, or NP (Signature) Date Contact Number

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Physician, PA, or NP (Printed) Address