UNIVERSITY OF NORTH CAROLINA HEALTH CARE VACCINATION VERIFICATION FORM

Legal Name:_____ Date of Birth:_____

THIS FORM MUST BE COMPLETED AND SIGNED BY YOUR PERSONAL PHYSICIAN / NURSE PRACTITIONER / PHYSICIAN ASSISTANT. LIP SIGNATURE REQUIRED

TUBERCULOSIS SCREENING

Please choose ONE for the TB screening:		*Step 1*	*Step 2*	*Annual*
• TB Skin Tests (TST) - Must provide record of 2 tuberculin (TB) skin tests (each test consists of two steps) performed within a 12-month period. The 2nd TB test cannot be **placed** earlier than one week after the 1st one has been **read** (roughly 10 days from when the first test was placed).	Date Placed:			
	Date Read:			
	Induration (mm):			
	Result (Pos/Neg.):			
• IGRA (T-Spot, Quantiferon Gold, etc.)	Date:			
	Result:			
If you have a history of positive TB, then a chest x-ray is required (performed within the last two years; will need to provide documentation of official report).	Date:			

REQUIRED IMMUNIZATIONS

	Vaccinations		**Titer(s)**		
Tdap (One vaccine as an adult or child ≥ 11 years of age)	(#1)				
MMR Two MMR vaccinations at least 1 month apart given after age 1. ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination.	(#1)	(#2)	Titer positive date: Measles	Titer positive date: Mumps	Titer positive date: Rubella
Varicella (chicken pox) Series of two doses or immunity by positive blood titer.	(#1)	(#2)	Titer Positive date:		
Flu Vaccine (annually)	(#1)				
COVID Vaccination Must be 2 weeks after final series dose before volunteering	(#1)	(#2)			

RECOMMENDED IMMUNIZATIONS

	Vaccinations			**Titer**
	mo/day/year	mo/day/year	mo/day/year	Titer Date/Result
Hepatitis B Vaccine (Hepatitis B vaccine is a 3 vaccine series that is completed at intervals recommended by the CDC. If a negative HBsAB is found after a completed first series, a second series may be indicated. If a second negative HBsAB is resulted after a completed second series, diagnosis of non-responder.)	*1st Series*			
	(#1)	(#2)	(#3)	Titer
	2nd Series (if given)			
	(#1)	(#2)	(#3)	Titer

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_____

Signature of Physician/Nurse Practitioner/Physician Assistant Date

_____

Printed name of Physician/Nurse Practitioner/Physician Assistant Phone number

_____

Office Address City State Zip Code