

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: <ul style="list-style-type: none"> • TB Skin Tests (TST) – 2-step history with at least one test in the last 12 months. (Per the CDC, the 2nd TB skin test must be placed at least 1 week AFTER the 1st one is read/checked; this process takes about 12-14 days; TB tests must be within the past 12 months) 		<i>Step 1</i>	<i>Step 2</i>	<i>Annual</i>
	Date Placed:			
	Date Read:			
	Induration (mm):			
	Result (Pos/Neg.):			
<ul style="list-style-type: none"> • 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 narrative 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.)	<i>1st Series</i>			
	(#1)	(#2)	(#3)	Titer
	<i>2nd Series (if given)</i>			
	(#1)	(#2)	(#3)	Titer

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LIP SIGNATURE REQUIRED

Signature of Physician/Nurse Practitioner/Physician Assistant _____

Date _____

Printed name of Physician/Nurse Practitioner/Physician Assistant _____

Phone number _____

Office Address _____

City _____

State _____

Zip Code _____