



2010

IMMUNIZATION VERIFICATION FORM

All students and observers who have contact with patients at Loyola University Medical Center and Loyola EMS System affiliate agencies and institutions must comply with LUMC Hospital Infection Control policies.

**NOTE: Incomplete immunization information will preclude enrollment into the EMT-Paramedic Program.**

Last name	First Name	MI
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**ALL LABORATORY/TEST RESULTS MUST BE ATTACHED**

**TUBERCULIN TEST**

PPD skin test is valid for one year from date read. Student must have a valid test result on file throughout the duration of the course. If positive skin test, chest x-ray required every 4 years.

<input type="checkbox"/> PPD (Mantoux) test within the past year (Tine or monovac not acceptable)	Result mm: _____ Induration	Date
	Must be read by MD, ARNP, PA, RN 48 to 72 hours after receiving	
<input type="checkbox"/> Positive PPD – Chest X-ray required	X-Ray Result <input type="checkbox"/> Positive <input type="checkbox"/> Negative	
Treatment type *	Duration	

\* Please provide MD report of current or past treatment.

**BLOOD TEST**

Provide proof of immunity by **attaching Serologic confirmation (blood titer) of immunity lab results to this form** for all of the following:

<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Varicella
<input type="checkbox"/> Rubella	<input type="checkbox"/> Hepatitis B	

**NOTE: If blood test does not show immunity for any of the above, attach copy of follow-up immunization record. If you have not had the Hepatitis B series, or blood test does not show immunity, you should begin this process as soon as possible to comply with this requirement.**

**HEPATITIS B**

The Hepatitis B series takes for to six months to complete.

Dose 1 _____ month/day/year	Dose 2 _____ month/day/year	Dose 3 _____ month/day/year
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**Td (TETANUS/DIPHERIA)**

Must be within ten years of the first day of the course.

Date \_\_\_\_\_  
month/day/year

Signature of Heathcare Provider

Date

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