

IMMUNIZATION FORM

St. Luke's International Hospital

PART I : To be completed by the **visitor/observer**. (Please Print)

| | | | | |
|----------------------------|-------|----------------|---------------|---------|
| _____ | _____ | _____ | MM / DD / YY | _____ |
| Last Name | First | Middle Initial | Date of Birth | Sex |
| Address: Number and Street | | City | Zip | Country |

PART II : To be completed and signed by a physician, nurse practitioner or physician's assistant. All dates must include month, day and year. (Check appropriate box.)

| MEASLES (Rubeola) : Vaccination OR serologic evidence of immunity through a blood test | |
|--|---|
| 1. Immunization with live virus vaccine? (Two doses are recommended but not required.) <input type="checkbox"/> | Dates of immunization: MM DD YY First _____ / _____ / _____ (Second _____ / _____ / _____) |
| 2. Immunity confirmed by blood titer? <input type="checkbox"/> | Date of Test _____ / _____ / _____ |
| 3. Exemption? <input type="checkbox"/> | Attach signed statement |
| MUMPS : Vaccination OR serologic evidence of immunity through a blood test | |
| 1. Immunization with live virus vaccine? <input type="checkbox"/> | Date of immunization: MM DD YY _____ / _____ / _____ |
| 2. Immunity confirmed by blood titer? <input type="checkbox"/> | Date of Test _____ / _____ / _____ |
| 3. Exemption? <input type="checkbox"/> | Attach signed statement |
| RUBELLA (German Measles) : Vaccination OR serologic evidence of immunity through a blood test | |
| 1. Immunization with live virus vaccine? <input type="checkbox"/> | Date of immunization: MM DD YY _____ / _____ / _____ |
| 2. Immunity confirmed by blood titer? <input type="checkbox"/> | Date of Test _____ / _____ / _____ |
| 3. Exemption? <input type="checkbox"/> | Attach signed statement |
| TETANUS/DIPHTHERIA : A Tetanus/Diphtheria (Td) booster dose within 10 years | |
| 1. Most recent booster. (Within 10 years) <input type="checkbox"/> | Date of immunization: MM DD YY _____ / _____ / _____ |
| 2. Exemption? <input type="checkbox"/> | Attach signed statement |
| VARICELLA : Vaccination OR serologic evidence of immunity through a blood test OR statement from the diagnosing physician that the visitor/observer has had varicella disease | |
| 1. Immunization with live virus vaccine? (Two doses are recommended but not required.) <input type="checkbox"/> | Dates of immunization: MM DD YY First _____ / _____ / _____ (Second _____ / _____ / _____) |
| 2. Immunity confirmed by blood titer? <input type="checkbox"/> | Date of Test _____ / _____ / _____ |
| 3. Disease confirmed by physician's records? <input type="checkbox"/> | Date of Illness _____ / _____ / _____ Signature of Physician _____ |
| 4. Exemption? <input type="checkbox"/> | Attach signed statement |

TUBERCULIN SKIN TEST : Two-step Mantoux test administered one week apart within three months prior to submission of the Immunization Form. Visitors/Observers with a positive skin test history are required to submit a report of a chest x-ray taken within the past 12 months.

| | |
|---|---|
| 1. Two-step Mantoux test? <input type="checkbox"/> | MM DD YY Test1 _____ / _____ / _____ Reading _____ mm Test2 _____ / _____ / _____ Reading _____ mm |
| 2. Positive PPD, chest x-ray required? <input type="checkbox"/> (Chest x-ray report within the past 12 months is required) | Date of Chest X-Ray _____ / _____ / _____ Results of chest x-ray <input type="checkbox"/> Positive <input type="checkbox"/> Negative INH therapy taken: <input type="checkbox"/> YES <input type="checkbox"/> NO Date started: _____ / _____ / _____ length of treatment _____ months |

HEPATITIS B: Three doses of HB vaccine **OR** serologic evidence of immunity through a blood

| | |
|--|---|
| 1. Three(3) doses of Hepatitis B vaccine? <input type="checkbox"/> | Dates of immunization: MM DD YY First _____ / _____ / _____ Second _____ / _____ / _____ Third _____ / _____ / _____ |
| 2. Immunity confirmed by blood titer? <input type="checkbox"/> | Date of Test _____ / _____ / _____ |
| 3. Exemption? <input type="checkbox"/> | Attach signed statement |

POLIO: A complete primary series of polio immunization is required for visitors/observers from countries listed by the WHO as endemic for wild poliovirus (currently **Nigeria, India, Pakistan and Afghanistan**) only.

| | |
|---|--|
| 1. Primary series completed? <input type="checkbox"/> | Date of immunization: MM DD YY / / |
| 2. Last booster? <input type="checkbox"/> | MM DD YY Date of immunization: _____ / _____ / _____ |
| 3. Exemption? <input type="checkbox"/> | Attach signed statement |

I attest that all dates and immunizations listed above are correct and accurate.

Provider's Signature _____
 Physician, Nurse Practitioner or Physician's Assistant

Provider's name printed _____

Provider's Address and Phone Number _____
