COLORADO MESA UNIVERSITY

Department of Health Sciences

Immunization/Documentation Quick Reference Form

Name_____ Date: _____(M) _____(D) _____ (Y)
Last First Middle (Maiden)

Local Address _____
Street City State Zip

Birth date (include year)_____ **CMU ID #** 700_____

Please Choose Your Program: ❑ PN ❑ LPN-AAS ❑ BSN ❑ RN-BSN ❑ MSN ❑ DNP ❑ AAS RAD TECH ❑ BAS RAD TECH ❑ EMT ❑ MLT ❑ Phlebotomy

Immunization Record (required) ***(must submit all supporting documentation, i.e. physician signed immunization card, etc. along with this form)****:*

Tuberculin Skin Test (TST) **(Yearly)**: Most recent TST must have been read within 12 months. Second TST must then have been read within 365 days from the most recent TST date to be in compliance.

TST#1 Date: _____(M) _____(D) _____ (Y) / TST #1 Results ☐ positive* ☐ negative ***(provide signed immunization form for proof)***

TST#2 Date: _____(M) _____(D) _____ (Y) / TST #2 Results ☐ positive* ☐ negative ***(provide signed immunization form for proof)***

*TST Result Positive, perform a Chest X-Ray, Date: _____(M) _____(D) _____ (Y) / Chest X-Ray Results ☐ positive ☐ negative

Tetanus, Diphtheria, Pertussis (TDap) **(Every 10 Years)**:
Date: _____(M) _____(D) _____ (Y) *(provide signed immunization form for proof)*

Influenza (Flu Shot) **(Every Fall)**:
Date: _____(M) _____(D) _____ (Y) *(provide signed immunization form for proof)*

Varicella **(once)**: Please enter one of the following information. ***(provide signed immunization form for proof)***

Varicella (Chicken Pox) verified by a Primary Care Provider Date: _____(M) _____(D) _____ (Y)

Varicella (Chicken Pox) Vaccination Date: _____(M) _____(D) _____ (Y)

Varicella (Chicken Pox) Titer Date: _____(M) _____(D) _____ (Y) / Immune ☐ Yes ☐ No**

***If immunity is "No", vaccination required, enter vaccination date above*

MMR **(once)**: Please enter the proof of two MMRs or the proof of immune positive Rubella, Rubeola, and Mumps Titer (***provide signed immunization form for proof)***

MMR #1 Date: _____(M) _____(D) _____ (Y) Rubella Titer Date: _____(M) _____(D) _____ (Y) / Immune ☐ Yes ☐ No**

MMR #2 Date: _____(M) _____(D) _____ (Y) -OR- Rubeola Titer Date: _____(M) _____(D) _____ (Y) / Immune ☐ Yes ☐ No**

Mumps Titer Date: _____(M) _____(D) _____ (Y) / Immune ☐ Yes ☐ No**

****If immunity is "No", vaccination required, enter vaccination date(s) at the left****

Hepatitis B Series **(once)**: Please enter the proof of the Hepatitis B three-shot series or the proof of immune positive Hepatitis B Titer ***(provide signed immunization form for proof)***

Hep B #1 Date: _____(M) _____(D) _____ (Y) -OR- Hepatitis B Titer Date: _____(M) _____(D) _____ (Y) / Immune ☐ Yes ☐ No**

Hep B #2 Date: _____(M) _____(D) _____ (Y) ****If immunity is "No", vaccination required, enter vaccination date(s) at the left****

Hep B #3 Date: _____(M) _____(D) _____ (Y)

CPR: Health Care Provider **(keep current)** ***Not required for MLTP or Phlebotomy Students***: ***(provide copy of CPR card)***

Issue Date: _____(M) _____(D) _____ (Y) Expiration Date: _____(M) _____(D) _____ (Y)

Liability Insurance **(keep current)**: ***(provide copy of policy form from your provider)***

Issue Date: _____(M) _____(D) _____ (Y) Expiration Date: _____(M) _____(D) _____ (Y)

Personal Health Insurance **(keep current)**: ***(provide copy of policy form from your provider)***

Issue Date: _____(M) _____(D) _____ (Y) Expiration Date: _____(M) _____(D) _____ (Y) Insurance Provider: _____

Type of proof: Insurance Card with Your Name/Policy Number ☐ Insurance Card with Parent Name/Policy Number & Supporting Documentation ☐

******The Primary Care Provider's signature below is only for the physical/mental capacity requirements. Supporting documentation is required for all of the above immunizations******

Students are required to be physically and mentally able to meet demands of clinical practice. The physical and mental capacity requirements are available on the Department of Health Sciences website.

This student received a physical examination on _____(M) _____(D) _____ (Y) and is physically and mentally able to meet the demands of clinical practice, and has no functional limitations for movement or lifting of 50 pounds.

Date: _____(M) _____(D) _____ (Y) Signature: _____ Printed Name:_____
Physician/Primary Healthcare Provider

Address: _____

_____

Revised: 10/16/13