



I will be doing a: clinical rotation/practicum or
 only shadowing. In what state and town at Mercy? _____

Mercy Health System Student/Shadow Vaccination Verification Form

Legal Name (Print): _____ Date of Birth: _____

The **required** immunizations **MUST BE** documented on this form. **Signature is required** by your School Nurse, Personal Physician, Nurse Practitioner or Physician Assistant to attest to accuracy.

TUBERCULOSIS SCREENING (Required)			
Two TB skin tests within the last 12 months. These are two TB skin tests with the second TST repeated 7-21 days after first TB skin test is read. <div style="border: 1px solid black; padding: 2px; display: inline-block;">OR</div>		First skin test (required)	Second skin test (required 1-3 weeks after first test)
	Date Placed:		
	Date Read:		
	Induration (mm):		
	Result (Pos/Neg):		
A TB blood test within the last 12 months (IGRA) (T-Spot, Quantiferon Gold, etc.)	Date:		Result:
Chest x-ray - in the last two years with documentation of official report (for positive results only)	Date:		

REQUIRED IMMUNIZATIONS									
	Vaccinations				Titer(s)				
Tdap (One vaccine within the last 10 years)	Date: _____								
MMR Two MMR vaccinations at least 1 month apart given after age 1 ---OR--- Born prior to 1957 (exempt) ---OR--- Positive titers to Measles, Mumps, and Rubella ---OR--- Documentation of 2 Measles, 2 Mumps, and 1 Rubella vaccination	(#1)	AND	(#2)	OR	Titer positive date: Measles	AND	Titer positive date: Mumps	AND	Titer positive date: Rubella
					Titer positive date: _____				
Varicella (chicken pox) - Series of two doses or immunity by positive blood titer	(#1)	AND	(#2)	OR	Titer positive date: _____				
Flu Vaccine (if at Mercy between October 1 - March 31) Date subject to change per CDC	Date: _____								
Hepatitis A (required only for students and shadowers in Daycare or Nutrition/Food Service)	N/A	OR	(#1)	AND	(#2)	OR	Hep A Titer Date: _____		

RECOMMENDED IMMUNIZATIONS				
COVID Vaccine	date of INITIAL series completion: _____	date of LAST booster: _____	student declined <input type="checkbox"/>	
Hepatitis B Vaccine	Vaccinations			Titer
	mo/day/year	mo/day/year	mo/day/year	Titer date/result
(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)	Date: _____
				Result: _____
	<i>2nd Series (if given)</i>			
(#1)	(#2)	(#3)	Date: _____	
			Result: _____	

Information **MUST** be verified and signed by the student/shadower's School Nurse, personal Physician, Nurse Practitioner, or Physician Assistant. **Signature attests to accurate immunization documentation.**

_____/_____
Signature (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) with **Credentials** **Date:** _____

_____/_____
Printed Name (of School Nurse/Physician/Nurse Practitioner/Physician Assistant) **Office Phone #:** _____
 School or Provider Office Address/City/State: _____

Return this form in order to receive approval to start your learning experience at Mercy:

- **Clinical rotation students send to MercyStudentExperiences@mercy.net**
- **Shadower/Observers send to MercyShadowExperiences@mercy.net**