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 2-step TB skin tests within the last 12 months. These are two TB skin tests placed at least 1 week apart but **within 1 year**		***First skin test (required)***	***Second skin test (required at least 1 week after first test)***
	Date Placed:		
	Date Read:		
OR	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**
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				
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.)	*1st Series*			
	(#1)	*(#2)*	*(#3)*	*Date:* *Result:*
	2nd Series (if given)			
	(#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 within 30 days of submitting your application to:

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