SOUTH COUNTY HEALTH

SUBMIT TO EMPLOYEE HEALTH

IMMUNIZATION & TB SCREENING RECORD

PLEASE PRINT CLEARLY

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Cell Phone: _____ **Email:** _____

Department: VOLUNTEER SERVICES DEPT. **Date of Birth:** _____

Patient Accounts: *Please code* ***SCVOLUNTEERS*** *to eliminate receiving a bill for titers.*

MEASLES, MUMPS, & RUBELLA

Immunizations & Dates (Please check all that apply & date)

Positive Titers	MMR Vaccine	Measles Vaccine	Mumps Vaccine	Rubella Vaccine
· Measles Date: _____	Date #1 _____	Date #1 _____	Date #1 _____	Date #1 _____
· Mumps Date: _____	Date #2 _____	Date #2 _____	Date #2 _____	Date #2 _____
· Rubella Date: _____	**OTHER INFORMATION:**			

VARICELLA (CHICKEN POX)

Titer	Varicella Vaccine
Date: _____	Date #1: _____
Results: _____	Date #2: _____

☐ History of Varicella/Chicken Pox

COVID VACCINE

Date #1: _____ Brand: _____

Date #2: _____ Brand: _____

Date #3: _____ Brand: _____

Tdap

Immunizations & Dates (Please check all that apply & date)

Tdap Vaccine Date: _____

INFLUENZA

Only Required During Flu season 10/1–3/31

Influenza Vaccine Date: _____

TB SCREENING

Tests & Dates (Please check all that apply & date)

Negative PPD	Positive PPD	T-Spot
Step #1: _____	Step #1: _____	Date #1: _____
Results: _____ mm	Results: _____ mm	Result: _____
Step #2: _____	Chest XRay Date: _____	
Results: _____ mm	Interpretation: _____	

The signature below verifies this prospective volunteer has completed all health screening requirements according to South County Health Volunteer Services Policy.

Signature of Clinician _____ **Print Name** _____ **Date** _____