SOUTH COUNTY HEALTH

SUBMIT TO EMPLOYEE HEALTH

Immunization & TB Screening Record

Please print clearly:

Patient Name: (Last, First, M.I.)

Best Contact (email or phone):

Volunteer Services Department

Date of Birth:

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

Measles, Mumps, & Rubella

Immunizations & Dates: (Please check all that apply & date)	☐ Positive Titers Measles Date:_____ Mumps Date:_____ Rubella Date:_____	☐ MMR Vaccine Date #1:_____ Date #2:_____	☐ Measles Vaccine Date #1:_____ Date #2:_____	☐ Mumps Vaccine Date #1:_____ Date #2:_____	☐ Rubella Vaccine Date:_____ n/a
		Other Information:			

Varicella (Chicken Pox)

Immunizations & Dates: (Please check all that apply & date)	☐ Titer Date:_____ Results:_____	☐ Varicella Vaccine Date #1:_____ Date #2:_____	

	Tdap	**Influenza** (only required during flu season 10/1-3/31)
Immunizations & Dates: (Please check all that apply & date)	☐ Tdap Vaccine Date:_____ Other Information:	☐ Influenza Vaccine ☐ N/A Date:_____ Other Information:

TB Screening

Tests & Dates: (Please check all that apply & date)	☐ Negative PPD Step #1:_____ Result: ____ mm Step #2:_____ Result: ____ mm	☐ Positive PPD Date:_____ Result: ____ mm ☐ Chest XRay Date:_____ Interpretation :	☐ T-Spot Date #1:_____ Result: _____

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*