MSJMC
MOUNT ST. JOHN'S MEDICAL CENTRE

Immunization Verification Record

Copies of the required immunization records must be documented, verified and attached to this form.

Part 1: To be completed in PRINT by the student

Last Name:		First Name Middle Name:	
Date of Birth (mm/dd/yyyy):		Clinical Rotation Dates:	
Name of School:		Student ID:	
Address (Number and Street):		City and State:	
Country:		Zip Code:	

Part 2: To be completed and signed by a health care provider. All dates must include month, day and year (mm/dd/yyyy).

		Date (mm/dd/yyyy)	Details / Titer results and dates
Tuberculosis Screening PPD (Mantoux) *Required within 6 mths of clinical rotation*	Most recent PPD Date:		
	Result:		
	If positive (MM induration and date of +):		**CXR**________________**Interferon Gold**______________
Measles/Mumps/Rubella (MMR)	MMR #1		Measles Titer
	MMR #2		Mumps Titer
	Any additional MMR?		Rubella Titer
Tetanus and Diphtheria (TD or DT or DPT)	**a. Primary series complete? (At least three dose dates are required)**		
	Series 1		
	Series 2		
	Series 3		
	b. Most recent booster? Date: (Must be within the last 10 years)		
	c. Exemption?		
	Attach physician's statement of medical contradiction with duration of medical condition or attach your personal statement of philosophical/religious objection to immunization.		
Varicella (Chicken Pox)	Did you have disease? Fill in "x" [ ]YES [ ]NO		
	Varicella #1		
	Varicella #2		
	Any additional/booster Varicella?		
Hepatitis B	Hepatitis B #1		
	Hepatitis B #2		
	Hepatitis B #3		
	Any additional/booster Hep. B?		
SAR2 COVID-19	1st Dose		
	2nd Dose		
	3rd Dose		

Health care provider verifying information for Part 2

Physician Details	Name:	
	Signature:	**Date (mm/dd/yyyy)**
	Address:	

FOR MSJMC USE ONLY

Date Received: ………………………………….

Date Verified: ………………………………….

Verified By: ………………………………………………………… …………………………………………
PRINT **SIGNATURE:**