UCONN HEALTH

Student Health Service
263 Farmington Ave.
Outpatient Pavilion
Farmington, CT 06032-8024

(Patient Identification)

IMMUNIZATION DOCUMENTATION FORM

First Name_____ Last Name_____ Date of Birth _____
T#_____

EMPLOYEE	**Resident**	**Student**	**Grad Student**	**Volunteer**
Department:	Medical	Medical	MPH	Adult
_____	Dental	Dental	PhD	Youth
Job Title:	Start Yr._____	Start Yr._____	**Post-Doctorate**	Summer
_____				

COVID-19 VACCINES REQUIRED
1st vaccination ___/___/___ Manufacturer_____ Lot#_____ Booster ___/___/___
2nd vaccination ___/___/___ Manufacturer_____ Lot#_____ Manufacturer _____Lot#_____

INFLUENZA VACCINE REQUIRED
vaccination _____/_____/_____

MMR VACCINATIONS **OR** **POSITIVE TITER**
1st vaccination ___/___/___ Date of Measles titer ___/___/___ Immune Not immune
2ndvaccination ___/___/___ Date of Mumps titer ___/___/___ Immune Not immune
Date of Rubella titer ___/___/___ Immune Not immune

VARICELLA VACCINATIONS **OR** **POSITIVE TITER**
1st vaccination ___/___/___ Date of Varicella titer ___/___/___ Immune Not immune
2ndvaccination ___/___/___ Verbal History of illness: (*circle*) YES NO

Tetanus diphtheria Td **WITHIN LAST 10 YEARS** **Tetanus diphtheria accellular pertussis Tdap**
Date of last booster dose _____/_____/_____ Date of vaccine _____/_____/_____

TUBERCULOSIS: 2 TUBERCULIN SKIN TESTS WITHIN PAST 12 MONTHS REQUIRED
Type PPD 1st _____/_____/_____ PPD 2nd _____/_____/_____
Result *(circle)* Positive (mm) Negative Positive (mm) Negative
If positive PPD, Chest x-ray result must be within 12 months.
Chest x-ray date _____/_____/_____ TB Quantiferon Gold Date ___/___/___
Results (*circle*) Negative Positive Results *(circle)* Positive Negative
BCG History: (*circle*) YES NO

HEPATITIS B VACCINATIONS **Titer Post Vaccination Required (**Not required for Volunteers**)**
History of Hepatitis B infection? *(circle)* Yes No Previously vaccinated *(circle)* Yes No Unknown
1st Dose ___/___/___ 4th Dose ___/___/___
2nd Dose ___/___/___ 5th Dose ___/___/___
3rd Dose ___/___/___ 6th Dose ___/___/___
Titer Date _____/_____/_____ Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative Titer Result *(circle)* Positive Negative

The documentation above was completed by:

_____ _____ _____
Name of Health Care Provider *(print)* Telephone Number Address

_____ _____
Signature of Health Care Provider Date/Time

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT, OR SEND OR FAX TO:
UCONN HEALTH, SECTION OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE, MEDICAL RECORDS,
263 FARMINGTON AVENUE, FARMINGTON, CT 06030-6210
Fax# 860-679-4587 **Telephone#** 860-679-2893

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IMMUNIZATION CONSENT / DECLINATION FORM

First Name _____Last Name _____ Date of Birth _____

CONSENT

I have read or have had explained to me the information on the Vaccine Information Sheet. I have had a chance to ask questions which were answered to my satisfaction. I understand that due to my occupational exposure, whether by employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I believe I understand the benefits and risks of the vaccine and request that the vaccine checked above be given to me or to the person named below for whom I am authorized to make this request.

_____ _____ _____

Patient or Legal Guardian Signature | Relationship | Date/Time

Type of Vaccine: MMR **Order: Please administer 0.5ml subcutaneous**

#1 Date_____ Manufacturer _____Lot#_____ Exp_____Site _____VIS_____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot#_____ Exp_____Site _____VIS ____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

Type of Vaccine: Td or Tdap **Order: Please administer 0.5ml intramuscular**:

Manufacturer: _____ vis_____

Date _____ Lot#_____ Exp_____Site _____Provider _____

Type of Vaccine: Varicella **Order: Please administer 0.5ml subcutaneous**

#1 Date_____ Manufacturer _____Lot#_____ Exp_____Site _____VIS_____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot#_____ Exp_____Site _____VIS ____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

DECLINATION

I understand the information provided and explained to me on the vaccine. I understand that due to my employment, residency, clerkship or volunteering, I may be at risk of acquiring infection. I have been given the opportunity to be vaccinated with the vaccine. However, I decline vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring a serious disease. If in the future I continue to have exposure to this infectious disease and want to be vaccinated, I can receive the vaccine at that time.

Type of Vaccine: ***(circle)*** **MMR Varicella Td or Tdap**

_____ _____ _____

Patient or Legal Guardian Signature | Relationship | Date/Time

Reason for Declination:_____