UCONN HEALTH

UConn Medical Group
Employee Health Service
Occupational Medicine Clinic

(Patient Identification)

IMMUNIZATION DOCUMENTATION FORM

PLEASE BRING COMPLETED FORM WITH YOU TO YOUR APPOINTMENT. If your doctor cannot complete/sign this form please bring documentation of all required vaccines/tests

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 ___/___/___
2nd vaccination ___/___/___

Date of Measles titer ___/___/___ Immune Not immune
Date of Mumps titer ___/___/___ Immune Not immune
Date of Rubella titer ___/___/___ Immune Not immune

VARICELLA VACCINATIONS **OR** **POSITIVE TITER**

1st vaccination ___/___/___
2nd vaccination ___/___/___

Date of Varicella titer ___/___/___ Immune Not immune

Tetanus diphtheria Td **OR** **Tetanus diphtheria acellular pertussis Tdap** **MUST BE WITHIN THE LAST 10 YEARS**

Date of last booster dose _____/_____/_____ Date of vaccine _____/_____/_____

TUBERCULOSIS: ONE IGRA BLOOD TEST OR TWO TUBERCULIN SKIN TESTS WITHIN THE PAST 12 MONTHS

QuantiFERON Gold (date) ___/___/___ **OR** PPD 1st (date) ___/___/___ Result *(circle)* Positive Negative (mm)
Result *(circle) Positive* Negative

PPD 2nd (date) ___/___/___ Result *(circle)* Positive Negative (mm)

BCG History: (*circle*) YES NO **Note- PPD skin tests must be two weeks apart**

If positive IGRA blood test, Chest x-ray must be within 12 months **Chest x-ray** (date) __/___/___

HEPATITIS B VACCINATION: Hepatitis B Surface Antibody Titer (needed only if employee will be exposed to blood/body fluids on the job)

History of Hepatitis B infection? *(circle)* Yes No

1st Dose ___/___/___
2nd Dose ___/___/___
3rd Dose ___/___/___

Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative

Previously vaccinated *(circle)* Yes No Unknown

4th Dose ___/___/___
5th Dose ___/___/___
6th Dose ___/___/___

Titer Date _____/_____/_____
Titer Result *(circle)* Positive Negative

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

Signature of Health Care Provider Date/Time

HCH1544

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IMMUNIZATION CONSENT/DECLINATION FORM

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.

_____ _____

Employee Signature Date/Time

Type of Vaccine: MMR

#1 Date_____ Manufacturer _____Lot#_____ Exp. Date_____Site _____VIS_____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot#_____ Exp. Date_____Site _____VIS ____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

Type of Vaccine: Td or Tdap

Manufacturer: _____ vis_____

Date _____ Lot#_____ Exp. Date_____Site _____Provider _____

Type of Vaccine: Varicella

#1 Date_____ Manufacturer _____Lot#_____ Exp. Date_____Site _____VIS_____

Diluent Lot # _____ Diluent Exp. Date _____ Provider _____

#2 Date _____ Manufacturer _____ Lot#_____ Exp. Date_____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**

_____ _____

Employee Signature Date/Time

Reason for Declination:_____