

UConn Medical Group Employee Health Service **Occupational Medicine Clinic**

(Patient Identification)

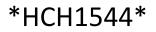
IMMUNIZATION DOCUMENTATION FORM

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 REQUIR			-	
1 st vaccination ////	Manufacturer	Lot#	Booster//	
2 nd vaccination//	Manufacturer	Lot#	Manufacturer	Lot#
INFLUENZA VACCINE REQUI	<u>RED</u>			
MMR VACCINATIONS	OR	POSITIV	E TITER	
1 st vaccination//				Immune Not immune
2 nd vaccination /////			1umps titer / /	
				Immune Not immune
VARICELLA VACCINATIONS 1 st vaccination/ 2 nd vaccination//	OR	POSITI	VE TITER 'aricella titer//	
Tetanus diphtheria Td Date of last booster dose/	OR		a acellular pertussis Tdap //	MUST BE WITHIN THE LAST 10 YEARS
TUBERCULOSIS: ONE IGRA B	LOOD TEST O	R TWO TUBERCUL	IN SKIN TESTS WITHI	IN THE PAST 12 MONTHS
QuantiFERON Gold (date) /// Result (circle) Positive Negative		PPD 1 st (date)/_	/ Result (circle) Po	ositive Negative (mm)
		PPD 2 nd (date) /	/ Result (circle) I	Positive Negative (mm)
BCG History: (<i>circle</i>) YES N	0	Note- PPD skin te	sts must be two weeks ap	art
If positive IGRA blood test, Chest x	-ray must be with	hin 12 months	<u>Chest x-ray</u> (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	Previously vaccinated (circle) Yes No Unknown
1 st Dose// 2 nd Dose// 3 rd Dose//	4 th Dose/ 5 th Dose/ 6 th Dose/
Titer Date// Titer Result (<i>circle</i>) Positive Negative	Titer Date// Titer Result (<i>circle</i>) Positive Negative
Name of Health Care Provider (print) Telephone Number	r Address
Signature of Health Care Provider	Date/Time





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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 #	Diluer	nt Exp. Date	Provider	Provider	
#2 Date	Manufacturer	Lot#	Exp. Date	Site	VIS
Diluent Lot #	Diluent Exp. Date		Provider		
Type of Vaccine:	<u>Td or Tdap</u>				
Manufacturer:		vis			
Date	Lot#	Exp. Date	SiteProvider		
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.

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

Employ	ee Signa	ture
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Date/Time

Reason for Declination: