ALLIED HEALTH
IMMUNIZATION RECORDS

STUDENT’S NAME (please print)

INDICATE PROGRAM:

___ Registered Nursing
___ Licensed Vocational Nursing
___ Certified Nursing Assistant
___ Radiologic Technology
___ Emergency Medical Technician
___ Paramedic Program

MMR/ MEASLES, MUMPS & RUBELLA IMMUNIZATION

Date of Vaccination: ________________
OR
Date of MMR Titer: ______________________  NEG: ___  POS: _____

NAME OF PHYSICIAN (print)  CALIFORNIA LICENSE NUMBER

Authorized Signature: ____________________________________________________

VARICELLA (CHICKEN POX) IMMUNIZATION
*A note from your doctor or parent saying you've had the chicken pox will NOT be accepted

Date of Vaccination: ________________
OR
Date of Varicella Titer: ______________________  NEG: ___  POS: _____

NAME OF PHYSICIAN (print)  CALIFORNIA LICENSE NUMBER

Authorized Signature: ____________________________________________________

HEPATITIS B SERIES

Dates of Vaccines: 1st: _______  2nd: _______  3rd: _______
OR
Date of Hepatitis B Titer: ______________________  NEG: ___  POS: _____

NAME OF PHYSICIAN (print)  CALIFORNIA LICENSE NUMBER

Authorized Signature: ____________________________________________________