

**PARKER UNIVERSITY**

**DIAGNOSTIC SONOGRAPHY PROGRAM**

**Immunization**

**Dated test results must be submitted with this form**

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Student ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**** **Tuberculosis Test:**

or Tine Positive \_\_\_\_\_\_\_\_ Negative \_\_\_\_\_\_\_\_

or Tuberculin Positive \_\_\_\_\_\_\_\_ Negative \_\_\_\_\_\_\_\_

or Chest x-ray Positive \_\_\_\_\_\_\_\_ Negative \_\_\_\_\_\_\_\_

** Hepatitis B injections:** **OR ** **Hepatitis B titer**

#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ Titers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#3\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Measles, Mumps, Rubella injections: OR  MMR titer**

#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ Titers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Varicella injections: OR  Varicella titer**

#1\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_ Titers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#2\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Tetanus** (Records must reflect a Diphtheria Tetanus Toxoid Booster within the last ten years)

Date of Booster \_\_\_\_\_\_\_\_

 **Meningitis (MV)** (30yrs old or younger)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Titers\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

** Influenza** (Required annually during flu season)

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize release either verbally or in writing, the information contained in the health records to Parker University and its Clinical Affiliates.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prospective Student Name (print)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_

Prospective Student Signature Date