FEIK School of PHARMACY

STUDENT IMMUNIZATION RECORD

NAME (print or type): **Date of Birth:**

UIW ID: **Contact Phone #:**

Program entering: ☐ **Pharmacy Technician** ☐ **Pharm D**

HEPATITIS B ONLY *OR* HEPATITIS A&B COMBO VACCINE: Brand:

DATE ADMINISTERED: 1.) 2.) 3)

OR

Hepatitis B Antibody Titer: Date: Immune: ☐ Not Immune: ☐ Value:

TUBERCULOSIS (TB Screen/PPD): Date Placed: Date Read:

Results: mm Positive ☐ Negative ☐

OR

QUANTIFERON TB GOLD *or* TSpot: Results: Positive ☐ Negative ☐

If positive reading: CXR: DATE TAKEN: CXR Results:

VARICELLA (Chickenpox) Brand: Varivax 1ST Immunization Date: 2nd Immunization Date:

OR

Varicella Titer Date: Immune: ☐ Not Immune: ☐ Value:

MEASLES (RUBEOLA), MUMPS, and RUBELLA: 1st Immunization Date: 2nd Immunization Date:

Brand: MMR II

O R

Measles Titer Date: Immune: ☐ Not Immune: ☐ Value:

Mumps Titer Date: Immune: ☐ Not Immune: ☐ Value:

Rubella Titer Date: Immune: ☐ Not Immune: ☐ Value:

Tdap (Tetanus, Diphtheria, & Pertussis):
Last Booster Date:

FLU (During current flu season only):
Date:

Meningitis ACWY (If age <22 Years)
Date:

COVID VACCINE (May be required by clinical certain clinical agencies for practicum):

1st Shot Date:
2nd Shot Date:
Booster Shot Date:

By signing below, I certify that the information above is true and correct:

Title (RN, APRN, PA, MD, or DO):

PROVIDER NAME (print):

Signature:

Daytime Phone:

Date:

For office use only

Reviewer Signature: **Date:**