Health Record Form

Please have all 3 pages of this form **completed and signed** by a healthcare provider.
You will not be permitted to participate in clinical experiences if your health record is incomplete.

Name:_____ Date of Birth:_____/_____/_____

Annual Tuberculosis Screening:

On an annual basis, you are required to provide proof of Tuberculosis screening through one of the following:

1) TB skin test: A two-step (4 visits) Mantoux PPD performed within 1-3 weeks apart
2) Blood Test: QuantiFERON, T-Spot, or IGRA blood draw
3) Chest X-Ray: If any TB testing is positive, a chest x-ray is done to rule out active Tuberculosis. Only Chest x-rays that are less *than one year old, and state specification is for a history of positive PPD skin test, or positive QuantiFERON, or T-Spot blood test will be accepted.*

Option 1: Two-step Mantoux PPD

PPD Step #1
Date Administered:_____/_____/_____ Date Read:_____/_____/_____ Result in mm: _____
Step #1 PPD Results: ☐ NEGATIVE ☐POSITIVE
PPD Step #2
Date Administered:_____/_____/_____ Date Read:_____/_____/_____ Result in mm: _____
Step #2 PPD Results: ☐ NEGATIVE ☐POSITIVE

Option 2: Blood Test ****Luminis Health's Most Preferred Method****

☐ **QuantiFERON** ☐ **T-Spot** ☐ **IGRA (Result must be positive)**

Date:_____/_____/_____

Results: ☐ NEGATIVE ☐POSITIVE (requires Chest X-Ray)

Option 3: Chest X-Ray

Date:_____/_____/_____

Results: ☐ NORMAL ☐ABNORMAL

Name:_____ Date of Birth:_____/_____/_____

Measles, Mumps, Rubella (MMR) Series or Titer: A minimum of two doses of vaccine or positive quantitative IgG titer for all three. If one or more titers are negative, booster (or repeat two-dose series) required followed by repeat titer(s). **If received the 2 dose MMR series, no other testing required.**

MMR Series

1._____/_____/_____ 2._____/_____/_____

MMR Titer

Measles Titer:_____/_____/_____	Result: ☐IMMUNE ☐NON-IMMUNE/EQUIVOCAL
Mumps Titer:_____/_____/_____	Result: ☐IMMUNE ☐NON-IMMUNE/EQUIVOCAL
Rubella Titer:_____/_____/_____	Result: ☐IMMUNE ☐NON-IMMUNE/EQUIVOCAL

Hepatitis B Series and Titer: A minimum of three doses series **ONLY** if not previously received. **AND** a positive quantitative surface antibody (HBsAB) titer is required. If titer is **negative**, repeat doses are required, followed by repeat titer. **Students will be allowed on campus once they've received their first 1st dose of the repeated series.** ****Some manufacturers have made a 2 series vaccine, if you received that vaccine series, please write the name of the manufacturer below**** ***Declination is permitted, but must request Luminis Health declination form to have reviewed and signed by a provider.***

Hepatitis B Series

1.____/____/____ 2.____/____/_____ 3._____/____/____ **Manufacturer:**

Hepatitis B Titer

Titer:_____/_____/_____ Result: ☐IMMUNE ☐NON-IMMUNE/EQUIVOCAL

Varicella (Chickenpox) Series or Titer: A minimum of two doses of vaccine or positive quantitative IgG titer. If titer is negative, repeat doses are required, followed by repeat titer**. If received 2-dose Varicella series, no other testing required.**

Varicella Series

1._____/_____/_____ 2._____/_____/_____

Varicella Titer

Titer:_____/_____/_____ Result: ☐IMMUNE ☐NON-IMMUNE/EQUIVOCAL

Tetanus, Diptheria, and Pertussis (TDaP) Vaccine: 1 TDaP immunization received as an adult (18+).

TDaP Vaccine

1._____/_____/_____

Seasonal Influenza Vaccine: Seasonal influenza vaccine required annually October – March (Depending on start date). Influenza declination accepted only for medical or religious reasons (additional form).

Influenza Vaccine

1._____/_____/_____ ☐N/A (complete and attached declination form)

Name:_____ Date of Birth:_____/_____/_____

COVID-19 Vaccination: First dose of vaccine required by Sept 1, 2021. Must be fully vaccinated by October 1, 2021. ***If received Johnson and Johnson vaccination, only one dose is required. Please write the name of the manufacturer below**** COVID Vaccination declination accepted only for medical or religious reasons (Luminis Health approved medical declination form found in your NIRV system account. To be filled out and signed by a provider).

COVID-19 Vaccine

1. _____/_____/_____ 2 _____/_____/_____ ☐N/A (complete and attached declination form)

Manufacturer:

HEALTHCARE PROVIDER ATTESTATION

This form will not be accepted if not signed by a health care provider.

The information presented on this form is true and accurate to the best of my knowledge.

Provider Signature:_____Date:_____/_____/_____

Provider Name (printed):_____

Address:_____Phone: _____

Provider Type: ☐ MD ☐ DO ☐ PA ☐ APRN