

(Please print) Last Name, First, Middle Initial	Date of birth	Calvin ID #
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6. TUBERCULOSIS:

If you answered YES to any questions on the TB Self-Screening form, a TB Skin Test is required. **Please note:** A BCG vaccination does not exempt you from the need to receive a TB Skin Test if you answered yes to any questions on the self-screening form.

Tuberculin Skin Test Date Given: ____/____/____ Date Read: ____/____/____ Result: _____ mm <small>(record actual mm of induration; if no induration, write "0")</small>
Chest X-ray (Required if PPD is 10mm or greater. Please submit a copy of the x-ray report.) Date Given: ____/____/____ Result: _____ (normal/abnormal)
Blood Tests for TB T-Spot® TB: Date Given: ____/____/____ Result: _____ (include copy of lab report) QuantiFERON® TB Gold: Date Given: ____/____/____ Result: _____ (include copy of lab report)

7. M.M.R. (Measles, Mumps, Rubella)

Two doses of M.M.R. are **required**. Dose #1 given after first birthday. Dose #2 given at least 4 weeks after initial dose.

M.M.R. (MEASLES, MUMPS, RUBELLA)	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY
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OR

MEASLES TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): <input type="checkbox"/> Reactive/Immune <input type="checkbox"/> Non-reactive/not immune
MUMPS TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): <input type="checkbox"/> Reactive/Immune <input type="checkbox"/> Non-reactive/not immune
RUBELLA TITER	____/____/____ MM / DD / YYYY	Result (include copy of lab report): <input type="checkbox"/> Reactive/Immune <input type="checkbox"/> Non-reactive/not immune

8. OTHER IMMUNIZATIONS RECEIVED

i.e. HPV (recommended for males and females 11-26 years old), Hepatitis A (recommended for adolescents through age 18), Typhoid, Yellow Fever, Twinrix, etc.

	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY
	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY
	#1 ____/____/____ MM / DD / YYYY	#2 ____/____/____ MM / DD / YYYY	#3 ____/____/____ MM / DD / YYYY	#4 ____/____/____ MM / DD / YYYY	#5 ____/____/____ MM / DD / YYYY

Please have this form completed and signed by a health care professional, **or** submit an official photocopy of your records, and send to Health Services by October 1st. After that time, if you are still incompliant with Calvin College's requirements, a \$50 non-refundable fine will be placed on your miscellaneous account.

<u>REQUIRED HEALTH CARE PROFESSIONAL'S SIGNATURE</u> (Physician, Nurse, Health Dept. Stamp – not immediate family member): Print name _____ Address _____ Signature _____ Date ____/____/____ Phone () _____
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