# IMMUNIZATION FORM

California Institute of Medical Science

| Name (Last Name, First Name, Initial) | Physician/Medical Facility Address/Phone number |
|---|---|
| **Physician Name/Medical Facility** | |

| **IMMUNIZATIONS** | **Attach Official Immunization Documentation Dates & Results must be shown** | | **Signature/Initials from Authorized Personnel** |
|---|---|---|---|
| **Rubella Titer** | **Date** | **Results** | |
| | | | |
| **Rubeola (Measles) Titer** | **Date** | **Results** | |
| | | | |
| **Mumps Titer** | **Date** | **Results** | |
| | | | |
| **MMR Vaccine #1 (Mumps, Measles, Rubella)**<br>**MMR Vaccine #2 (required if born after 1957)** | **Date** | **Results** | |
| | | | |
| | | | |
| **Varicella #1 (Titer/Vaccine)**<br>**Varicella #2 (required if born after 1957)** | **Date** | **Results** | |
| | | | |
| | | | |
| **Quantiferon Gold or T-Spot for TB screening (Within the past 12 months)** | **Date** | **Results** | |
| | | | |
| **Required if positive TB Chest Film if TB +** | **Date** | **Results** | |
| | | | |
| ***Hep B***<br>*Within 15 years. Series must be started before beginning any program*<br>*or*<br>*Positive Hep B Titers* | **Series** | **Declination** | |
| | **#1** | | |
| | **#2** | | |
| | **#3** | | |
| *Within 10 years*<br>***Diphtheria/Tetanus*** | **Date** | | |

Return this form with original documents to CIMS. **Valid with Medical Facility Stamp:**

**Authorized Signature:** _____ **Date:**