Brookhaven College Immunization Record

Last Name _____ First Name _____ Middle Initial _____

Date of Birth _____ Student ID # _____ Program _____

MMR (Measles, Mumps, Rubella)

1. Date of immunization: ___/___/_____( )*
2. Date of immunization: ___/___/_____( )*

OR

Measles IGG: ___/___/___ Result: _____ ( )*

Mumps IGG: ___/___/___ Result: _____ ( )*

Rubella IGG: ___/___/___ Result: _____ ( )*

HEPATITIS B / TWINRIX (Hep A/B)

1. Date of immunization: ___/___/_____ ( )*
2. Date of immunization: ___/___/_____ ( )*
3. Date of immunization: ___/___/_____( )*
4. Hepatitis B surface antibody (REQUIRED)

Titer Date: ___/___/_____( )*

Result #: _____

5. Additional doses: ___/___/_____ ( )*

TB

PPD ST Given: ___/___/___ Read: ___/___/___ ( )*

Result : ☐ Negative ☐ Positive _____mm. ( )*

OR

IGRA/T-Spot Date: _____/_____/_____ ( )*

Chest X Ray Date: _____/_____/_____ ( )*

Result : ☐ Negative ☐ Positive ( )*

WITHIN THE LAST YEAR AND YEARLY THEREAFTER

MENINGITIS ACYW-135

Departmental Requirement for: EMT, Paramedic, and Nursing

1. Date of immunization: ___/___/_____( )*

*** WITHIN LAST FIVE (5) YEARS ***

VARICELLA

1. 2 Doses (30 days apart or more)

___/___/___ ( )* ___/___/___ ( )*

OR

2. Varicella IGG date: ___/___/___ ( )*

Result #: _____

Tdap/ tetanus, diphtheria and acellular pertussis

1. Date of immunization: ___/___/_____( )*

*** WITHIN 10 Years for ALL students ***

FLU VACCINATION

1. Seasonal Flu Shot: ___/___/_____ ( )*

Lot: _____ Expiration Date: ___/___/___

SIGNATURE: DATE:

**Please have the Brookhaven Health Center nurse / your physician or nurse practitioner sign.*

UPDATED 06/07/2018