EMPLOYE HEALTH SERVICES  
Virginia Commonwealth University Health System (VCUHS)

HISTORY/IMMUNIZATION RECORD

**Instructions:** To expedite your health assessment screening, you must have your Health Care Provider, Student Health or the Employee Health Office with your previous employer complete and sign this Immunization Record or provide a copy of your current records. The dates must include the month, day and year. Failure to complete this form will result in lab tests and immunizations which may be unnecessary.

<table>
<thead>
<tr>
<th>Name (print)</th>
<th>Last</th>
<th>First</th>
<th>M.I</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Month/Day/Year</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### A. Tuberculosis

- **Check appropriate box**
  - ☐ TST(PPD) skin test for previously negative reactors
    - Test results mm
    - Date of previous TST and results mm
  - ☐ If TST was positive/significant, include copy of chest x-ray report

- ☐ Completed recommended course of INH or Rifampin therapy
  - Yes ☐ No

- ☐ History of BCG Vaccine
  - Have you ever had a TST?
    - Yes ☐ No
  - Test results mm

- ☐ Quantiferon or T-Spot TB blood test (if applicable) results
  - Negative ☐ Positive

### B. Hepatitis B

- **Check appropriate box**
  - If you have Received Hepatitis B vaccine, please indicate the following:

<table>
<thead>
<tr>
<th>Dates of all vaccines received</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Dose Mo/Day/Yr</td>
</tr>
<tr>
<td>Second Dose Mo/Day/Yr</td>
</tr>
<tr>
<td>Third Dose Mo/Day/Yr</td>
</tr>
<tr>
<td>Fourth Dose Mo/Day/Yr</td>
</tr>
<tr>
<td>Fifth Dose Mo/Day/Yr</td>
</tr>
<tr>
<td>Sixth Dose Mo/Day/Yr</td>
</tr>
</tbody>
</table>

- ☐ Post-vaccine antibody test done?
  - Yes ☐ No

If yes, provide date and include report

Mo/Day/Yr

Revised 10/2012
□ Declined Hepatitis B vaccine

C. Measles (Rubeola), Rubella (German Measles) and Mumps

□ Dates of vaccine:
  Date of Dose 1
  Mo/Day/Yr
  Date of Dose 2
  Mo/Day/Yr

If titers were done for any of the above, you must include a copy of the report. If received as a single vaccine (ie mumps vaccine) list vaccine and date given below.

D. Varicella (Chickenpox)

☐ History of disease
  □ Yes  □ No
  If yes, date you had disease
  Mo/Day/Year

☐ Varicella titer has been done (must include report)
  □ Yes  □ No
  If yes, please provide the date
  Mo/Day/Year

☐ If received Varicella vaccine
  Date of Dose 1
  Mo/Day/Yr
  Date of Dose 2
  Mo/Day/Yr

E. Tetanus-Diphtheria

Date of last booster
  Mo/Day/Yr

F. Tdap (Tetanus/diphtheria/acellular pertussis)

☐ Check appropriate box
  □ Yes  □ No

If yes please provide date:
  Mo/Day/Yr

G. Color Vision

☐ Have you ever been tested for color vision?
  □ Yes  □ No

☐ Do you have any color vision deficiency
  □ Yes  □ No

Signature not required, if you have copies of your records.
Ex (Student health records, previous healthcare employer records, Dept of Health records)

Physician/Health Care Provider Name: _____________________________________________

Physician/Health Care Provider: __________________________________________ Date: ________ Phone: _____________________________

Address: ______________________________________________________________________

  Street      City   State    ZIP

Revised 10/2012