VCU Health System
Virginia Commonwealth University
MCV Hospitals and Physicians

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.

Name (print)			
	Last	First	M.I
Date of Birth			
	Month/Day/Year		

A. Tuberculosis

Check appropriate box

☐ TST(PPD) skin test for previously negative reactors
Test results _____ mm _____ Mo/Day/Yr

Date of previous TST and results _____ mm _____ Mo/Day/Yr

☐ If TST was positive/significant, **include copy of chest x-ray report** _____ Mo/Day/Yr

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

☐ History of BCG Vaccine ☐ Yes ☐ No

Have you ever had a TST? ☐ Yes ☐ No

Test results _____ mm _____ Mo/Day/Yr

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

Include copy of report

B. Hepatitis B

Check appropriate box

If you have Received Hepatitis B vaccine, please indicate the following:

Dates of all vaccines received

First Dose	Mo/Day/Yr	Second Dose	Mo/Day/Yr
ThirdDose	Mo/Day/Yr	Fourth Dose	Mo/Day/Yr
Fifth Dose	Mo/Day/Yr	Sixth Dose	Mo/Day/Yr

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

If yes, provide date and include report _____ Mo/Day/Yr

☐ 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)**
Check appropriate box

☐ 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: _____
Print

Physician/Health Care Provider: _____Date: _____Phone:
Signature

Address: _____
Street City State ZIP

Revised 10/2012