STUDENT/FACULTY IMMUNIZATION RECORD

A record of each student's/faculty's immunization history must be obtained by the school prior to beginning student/faculty rotation. School is responsible for maintaining immunization records for each student/faculty member. Please complete the form below.

Student Name		
School Name		**Phone Number**

ROTATION INFORMATION

Facility *(check one)*		Behavioral Health Center		Hoke Hospital
		Bladen County Hospital LLC		Highsmith-Rainey Specialty Hospital
		Cape Fear Valley Medical Center		Other_____
		Cape Fear Valley Outpatient Clinic(s)		

Rotation Dates	**Begins:**	**Ends:**

1. The above individual has been immunized or shows evidence of blood titers documenting immunity for the following illnesses:

Hepatitis B Series	**1st Dose Date:**	**2nd Dose Date:**	**3rd Dose Date:**
OR			
Hepatitis B Titer	**Titer Date:**	**Immunity:**	

May decline the Hepatitis B immunization, if so, please sign here:

Signature: _____Date: _____

MMR Vaccine Series	**1st Dose Date:**	**2nd Dose Date:**
OR		
Measles Titer	**Titer Date:**	**Immunity:**
Mumps Titer	**Titer Date:**	**Immunity:**
Rubella Titer	**Titer Date:**	**Immunity:**

Varicella Vaccine Series	**1st Dose Date:**	**2nd Dose Date:**
OR		
Varicella Titer	**Titer Date:**	**Immunity:**

Tdap (Tetanus, Diphtheria and Pertussis) within the past 10 years	**Tdap Vaccine Date:**

PPD Status - TB skin test within the last 12 months of first rotation at hospital	**Date:**	**Results:**

2. **Influenza Vaccine is required annually if clinical rotations are during the flu season (September – April) Influenza Vaccine Date: _____**

3. OSHA Bloodborne Pathogens Training: Yes ☐ No ☐

4. The above individual understands and agrees that he/she may have physical contact with patients' skin/environment or items that may have contact with patients' skin/ environments: 1) artificial nails or extenders are prohibited; 2) natural nails must be kept at less than ¼ inch beyond the fingertips; and 3) polish may be used, but if used, should be free of chips.

5. The above individual understands and agrees to wear all appropriate PPE (Personal Protective Equipment) to reduce the risk of disease transmission.

Signature\School Representative: _____Date: _____

Revised: 06/26/2023