Larkin University
College of Pharmacy

Enrollment Immunization Form

_____ _____
Student Name (PRINT) Date of Birth

Inform your provider that you are enrolling into a professional health care program, which involves direct patient care. The immunization requirements below are consistent with the Center for Disease Control (CDC) recommendations for health care workers and are required for enrollment into Larkin Health Sciences Institute College of Pharmacy.

MEASLES, MUMPS, and RUBELLA (MMR)
MMR Dose #1 Date Given ____/____/_____
MMR Dose #2 Date Given ____/____/_____

OR serologic immunity to each of the 3 diseases ***(laboratory results must be attached)***
Measles titer Date Performed ____/_____/____ Immune? Yes ____ NO ____
Mumps titer Date Performed ____/____/_____ Immune? Yes ____ NO ____
Rubella titer Date Performed ____/____/_____ Immune? Yes ____ NO ____

TETANUS-DIPTHERIA-PERTUSSIS
Tetanus/Diphtheria/Pertussis (Tdap) Date Given ____/____/_____
Tetanus/Diphtheria (Td) Booster Date Given ____/____/_____

Healthcare personnel are required to receive a single dose to Tdap as soon as feasible if they have not previously received Tdap and regardless of the time since their most recent Td vaccination. Following Tdap vaccination, routine Td booster shots must be received every 10 years.

VARICELLA (Chicken Pox)
Varicella Dose #1 Date Given ____/____/_____
Varicella Dose #2 Date Given ____/____/_____

OR serologic immunity ***(laboratory results must be attached)***
Varicella IgG Antibody titer Date Performed ____/____/_____ Immune? Yes ____ NO ____

A medical history of "chicken pox" is NOT sufficient evidence to support immunity.

HEPATITIS B (Hep B)
Hep B Dose #1 Date Given ____/____/_____
Hep B Dose #2 Date Given ____/____/_____
Hep B Dose #3 Date Given ____/____/_____

AND serologic immunity ***(laboratory results must be attached)***
Hep B Surface Antibody titer Date Performed ____/____/_____ Immune? Yes ____ NO ____

Post vaccination serologic testing is required for all healthcare personnel at high risk for occupation percutaneous or mucosal exposure to blood or body fluids 1-2 months after administration of the last dose of the hepatitis B vaccine series.

I certify that the information above is complete and accurate to the best of my knowledge

Healthcare Provider Name (PRINT) _____ Date ____/____/_____

Healthcare Provider Signature _____

Facility Name & Address _____

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