

**Columbia State Community College
EMS Education
Paramedic Vaccination Verification Form**

Name of Student: _____ SS# _____
Please Print

Date: _____

NOTE: Attach all Lab and Radiology reports to this form.

Date of T.B. skin test (**required**): Date Administered: _____ Date Read: _____ Result: _____
Date Administered: _____ Date Read: _____ Result: _____

**NOTE: 2-step TB Skin Test (place test, check within 48-72 hours then repeat after 3 weeks)
within 12 months also 1 TB Skin Test within 3 months of start of clinical**

NOTE: If T.B. skin test is positive; you must submit a chest X-ray report. Date: _____ Results: _____
(must be within 6 months of clinical) (**Attach Radiologist's report**)

Date of Rubella Titer/IGG (**required**) _____ **Attach lab report for result:** _____

Date of Rubeola Titer/IGG (**required**) _____ **Attach lab report for result:** _____

Date of Mumps Titer/IGG (**required**) _____ **Attach lab report for result:** _____
2 MMR (**required if not immune to any of 3 above**) Date #1 _____ Date #2 _____

Date of Varicella Zoster titer/IGG (**required**) _____ **Attach lab report for result:** _____
If NOT immune: Date of Varicella Zoster immunization #1: _____ #2: _____

Have you had chicken pox? YES _____ NO/NOT SURE _____

Date of Tetanus (**required**): _____ *You must have a booster if your vaccination is over 10 years old*

Date of Hepatitis B series (received): #1 _____ #2 _____ #3 _____ **AND**
Date of Hepatitis B titer
(**Required if you have had the series**) (**Attach Hepatitis B titer lab report for results.**) _____

_____, M.D.
Physician's Signature

Physician's Address

_____, M.D.
Print or type Physician's Name