**HEALTH SCREENING FORM**

Name: ____________________________________  Date of Birth: _______/____/______

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**HEALTHCARE PROVIDER MUST COMPLETE (Not the Applicant)**

**INITIAL ONE OPTION IN EACH SECTION**

**PROVIDE DATES WHERE INDICATED**

**MEASLES, MUMPS AND RUBELLA**

___ Two (2) doses of MMR vaccine after first birthday  (vaccine dates: ___________ ___________)

___ One (1) dose of MMR vaccine after age 18 (vaccine date: _________________)

___ Serologic proof of immunity to measles, mumps and rubella
   (lab dates: measles__________  mumps__________  rubella__________)

___ Born prior to 1957 and has positive immunity to rubella (lab dates: __________ __________)

**VARICELLA** (A history of the disease is insufficient proof of immunity. Proof of immunity is only accepted via one of the following:)

___ Positive varicella titer  (lab date: ______________)

___ Varicella vaccine (vaccine dates: ____________  _____________)

**HEPATITIS B**

___ Three (3) doses of hepatitis B vaccines

___ Series begun, has had ___ of (3) Hepatitis-B immunizations

___ Signed declination of vaccine

**TUBERCULOSIS**

TB skin test within past 12 months:

___ Date of last TB skin test: ______________  Results: □ Negative  □ Positive

___ If Positive, date and result of last chest x-ray (with-in past 6 months) _____________________.

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I attest that I have reviewed the original documentation for all vaccines, X-rays and lab tests marked above and that the information is complete and accurate to the best of my knowledge:

Healthcare Provider Printed Name __________________________________ Date ____________

Healthcare Provider Signature _____________________________________________________

Office Phone Number (          ) __________________________________

Office Address_________________________________________________________