CRANSTON RIDGE MEDICAL CLINIC

CRANSTON RIDGE MEDICAL CLINIC HEALTH CARE WORKER IMMUNIZATION RECORD

WORKER'S FULL NAME _____

N.	VACCINE NAME	VACCINE ACRONYM	DOSAGE NUMBER	DATE OF APPLICATION	COMMENTS
1	Tetanus and Diphtheria	Td	1st 2nd 3rd		Last booster must be within last 10 years Date ___/___/_____ Date ___/___/_____
2	Pertussis	dTap	1		
3	Measles	MMR*	1st 2nd		*Serology evidence accepted in lieu of documentation*
4	Mumps	MMR*	1st 2nd		*Serology evidence accepted in lieu of documentation*
5	Rubella	MMR*	1		*Serology evidence accepted in lieu of documentation*
6	Hepatitis B	HBV	1st 2nd 3rd		
7	Varicella	Vz*	1st 2nd		*Serology evidence accepted in lieu of documentation*
8	Influenza	FLN	Annual		*Recommended but not necessary for employment*
9	Polio	IPV	1		*Recommended but not necessary for employment*
10	Meningococcal B	Men-B	1st 2nd		*Recommended but not necessary for employment*
11	Meningococcal Neisseria	Men-C ACYW	1		*Recommended but not necessary for employment*
12	Typhoid	TYVI	1		*Recommended but not necessary for employment*
13	Tuberculosis	PPD	1		*1 step TST or CXR accepted*

Health Care Provider's Name

_____

Health Care Provider's Signature

_____

Date

___/___/_____

STAMP