



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	1 st		Last booster must be within last 10 years Date ____/____/_____ Date ____/____/_____
			2 nd		
			3 rd		
2	Pertussis	dTap	1		
3	Measles	MMR*	1 st		<i>Serology evidence accepted in lieu of documentation</i>
			2 nd		
4	Mumps	MMR*	1 st		<i>Serology evidence accepted in lieu of documentation</i>
			2 nd		
5	Rubella	MMR*	1		<i>Serology evidence accepted in lieu of documentation</i>
6	Hepatitis B	HBV	1 st		
			2 nd		
			3 rd		
7	Varicella	Vz*	1 st		<i>Serology evidence accepted in lieu of documentation</i>
			2 nd		
8	Influenza	FLN	Annual		<i>Recommended but not necessary for employment</i>
9	Polio	IPV	1		<i>Recommended but not necessary for employment</i>
10	Meningococcal B	Men-B	1 st		<i>Recommended but not necessary for employment</i>
			2 nd		
11	Meningococcal Neisseria	Men-C ACYW	1		<i>Recommended but not necessary for employment</i>
12	Typhoid	TYVI	1		<i>Recommended but not necessary for employment</i>
13	Tuberculosis	PPD	1		<i>1 step TST or CXR accepted</i>

Health Care Provider's Name

Health Care Provider's Signature

Date

____/____/____

STAMP