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		Last booster must be within last 10 years
			2nd		Date ___/___/_______
			3rd		Date ___/___/_______
2	Pertussis	dTap	1		
3	Measles	MMR*	1st		*Serology evidence accepted in lieu of documentation*
			2nd		
4	Mumps	MMR*	1st		*Serology evidence accepted in lieu of documentation*
			2nd		
5	Rubella	MMR*	1		*Serology evidence accepted in lieu of documentation*
6	Hepatitis B	HBV	1st		
			2nd		
			3rd		
7	Varicella	Vz*	1st		*Serology evidence accepted in lieu of documentation*
			2nd		
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		*Recommended but not necessary for employment*
			2nd		
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