DENMARK TECHNICAL COLLEGE

Health and Wellness
Immunization/ Tuberculosis Screening Record

PART I

Name _____ _____
Last, First, M.I Telephone Number

Address _____
Street City State Zip

Date of Enrollment ___/_____ Date of Birth ___/___/_____ School ID# _____
M Y M D Y

Status: Part-time _____ Full-time _____ Graduate _____ Undergraduate _____

PART II: TO BE COMPLETED AND SIGNED BY YOUR HEALTH CARE PROVIDER.

All information must be in English.

A. MMR (MEASLES, MUMPS, RUBELLA) (Required)

(Two doses required at least 28 days apart for students born after 1956.)

1. Dose 1 given at age 12 months or later . ..... #1 ___/___/_____
M D Y
2. Dose 2 given at least 28 days after first dose . ..... #2 ___/___/_____
M D Y

OR positive antibody titer (blood test) lab report required

B. MENINGOCOCCAL QUADRIVALENT(Required) Polysaccharide acceptable

(A, C, Y, W-135) 2 doses; 2nd dose to be given after age 16

1. Quadrivalent conjugate (preferred; administer simultaneously with Tdap if possible).

a. Dose #1 ___/___/_____ b. Dose #2 ___/___/_____
M D Y M D Y

2. Quadrivalent polysaccharide (acceptable alternative if conjugate not available).

Date ___/___/_____
M D Y

C. TETANUS, DIPHTHERIA, PERTUSSIS (Required) (Must be within the last ten years)

Date of most recent booster dose: ___/___/_____ Type of booster: Td _____ Tdap _____
Must remain current throughout matriculation. M D Y *Tdap booster recommended for ages 11-64 unless contraindicated*

D. Additionally, the following vaccines are strongly recommended for all students

1. Varicella: ___/___/___:___/___/___
M D Y M D Y

2. Hepatitis A:_____/_____/_____:___/___/_____
M D Y M D Y

3. Hepatitis B:_____/_____/___:_____/_____/___:_____/_____/___
M D Y M D Y M D Y

4. Influenza: _____/_____/_____
M D Y

5. Meningitis B:_____/_____/_____:_____/_____/_____
M D Y M D Y

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Name:_____ School ID# _____

E. TUBERCULOSIS (TB) RISK ASSESSMENT (to be completed by **health care provider)**

Tuberculin Skin Test (TST) (Required within past 12 months)
(The TST interpretation should be based on mm of induration as well as risk factors.)

Date Given:____/____/____Time:
Date Read:____/____/____ Time:
M D Y

Result: _____ mm of induration (Must be numerical) !" #$ %&'()*$#+ ,-'*)- ./0.
An induration 10mm or above requires a chest x-ray

****Interpretation: Negative___ Positive ____**

Interferon Gamma Release Assay (IGRA): (specify method) QFT-GIT T-Spot other____

Result: negative___ positive___ indeterminate___ borderline___(T-Spot only)

Chest x-ray: (Required if TST induration is 10mm or above or IGRA is positive)

Date of chest x-ray:____/____/____ Result: normal____abnormal_____
M D Y

F. Medical Exemption:(Attach Verification by Healthcare Provider)

❑ Exemption on grounds of permanent medical contraindication

❑ Exemption on grounds of temporary medical contraindication- Expected end date___/___/_____
M D Y

G. Religious Exemption:

❑ I affirm that immunizations as required by Denmark Technical College are on conflict with my religious beliefs. Iunderstand that I am subject to exclusion in the event of a disease for which immunization is required. (**Attach Notarized Affidavit)**

Notice: Permission is hereby granted for Denmark Technical College Health Services staff and/or their consultants to carry out indication medical and surgical treatment. Major surgery or illness cases are transferred to other area hospitals. Permission will be sought by the hospital and attending private physician prior to surgery and/or treatment.

_____ _____
Signature of Student or Parent (If student is under the age of 18) **Date**

HEALTH CARE PROVIDER

Name_____Signature_____Date_____

Address_____ Phone (_____)_____

Input immunization dates and upload completed form to

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