



Name _____

Date: _____

SC ID# _____

ADN <input type="checkbox"/>	NA/HHA <input type="checkbox"/>
VN <input type="checkbox"/>	Dental Hygiene <input type="checkbox"/>

Directions: Complete all the sections below and bring your official immunization documentation for verification to the Health Sciences Division Office along with a copy to be kept in your Health Sciences Division record. ***Students who cannot complete or provide documentation of immunization requirements by the designated deadline will not be allowed to enroll in a Health Sciences program.***

Applicant is to record immunizations on this immunization record. (This form is a reporting document for Shasta College Health Sciences -- Not intended to be an official record from healthcare provider).

Influenza: Must show proof of either:	
A. One dose of influenza vaccine annually during the recommended flu season (October – February). OR	Date _____
B. A signed waiver on file	Date _____

Tetanus, Diphtheria, Pertussis (Tdap): Must show proof of either:	
A. One time dose of Tdap (includes pertussis) required for all Healthcare Personnel younger than age 65.	Date _____
B. Subsequent Td booster every 10 years following one-time Tdap.	Date _____

Varicella must show proof of:	
A. Two doses of Varicella vaccine administered 4-8 weeks apart (if received after age 13) OR	Date #1 _____ Date #2 _____
B. Serologic test positive for Varicella antibody	Date _____ Results _____

Measles, Mumps, Rubella (MMR) Must show proof of either:	
A. Two doses of measles vaccine (or MMR) on or after their first birthday 4-weeks apart OR	Date # 1 _____ Date # 2 _____
B. Serologic test positive for measles and rubella antibody	Date _____ Result _____ Date _____ Result _____



Hepatitis B: must show proof of:	
A. Three doses of vaccine administered over a period of 4-6 months. Minimum timeline: Second dose 4 weeks after initial dose and 3 rd dose 8 weeks after second with at least 16 weeks after first OR	Date # 1 _____ Date # 2 _____ Date # 3 _____
B. Serologic test positive for Hepatitis B antibody (at least 10 mIU/mL)	Date _____ Result _____

Tuberculosis Screening (annual while participating in program): Must show proof of:	
A. Two Negative PPD results within a 12- month time frame. 2 nd PPD must be within 6 months of starting program OR	Date # 1 _____ Result _____ Date # 2 _____ Result _____
B. If PPD is positive or there is a history of positive PPD, there must be a record of a negative chest X-ray within past 2 years and a TB screening questionnaire must be completed	Date _____ Result _____

CPR Certification must show proof of current certification in:	
Basic Life Support (BLS) for the Healthcare Professional including Adult, Child & Infant Resuscitation and two-person rescue.	Expiration Date: _____

Applicant Statement:

I hereby certify that all materials presented and all statements made are true and correct. I authorize investigation of all records submitted and am prepared to provide original records when requested. I understand that any misrepresentation of material facts may be cause for immediate disqualification and removal from the program.

Signature of Applicant: _____ Date: _____

For Health Sciences Division Use Only
Date Received:
Immunization official documentation verified by:

