Division of WORKFORCE PARTNERSHIPS
Adult Education

C.N.A. Student Immunization Form

Part A: Student Information

Date: _____ SS#: _____ Phone Number: _____

Student's Name: _____ Date of Birth: _____
Last, First, MI MM/DD/YY

Part B: Immunization Information

Measles (Rubeola)	**Vaccine 1:** _____/_____/_____ MM/DD/YY **Vaccine 2:** _____/_____/_____ MM/DD/YY **OR** applicable **Positive Titer Date:** _____/_____/_____	Attach lab work
Mumps	**Vaccine 1:** _____/_____/_____ MM/DD/YY **Vaccine 2:** _____/_____/_____ MM/DD/YY **OR** **Positive Titer Date:** _____/_____/_____	Attach lab work
Rubella (German Measles)	**Vaccine 1:** _____/_____/_____ OR **Positive Titer Date:** _____/_____/_____ MM/DD/YY MM/DD/YY	Attach lab work
Hep B Series	**Vaccine 1:** _____/_____/_____ **Vaccine 2:** ____/_____/____ **Booster**___/_____/____ **Positive Titer Date:** _____/_____/_____	
Varicella (Chicken Pox) Work	**Disease?** _____/_____/_____ **OR** **Vaccine 1:** _____/_____/_____ MM/DD/YY **Vaccine 2:** _____/_____/_____ **OR** Positive **Titer Date:** _____/_____/_____ MM/DD/YY MM/DD/YY	Attached Lab MM/DD/YY
Td or Tdap	Date: _____ MM/DD/YY	
	*Tdap replaces the Td for healthcare providers. Td=Tetanus & Diphtheria; Tdap=Tetanus Diphtheria & Pertussis. If your Tetanus is older than two years, Tdap is required. Tdap is good for 10 years.	

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Upon entry to the program, 2 skin test or a QuantiFERON Gold Blood test is required. For skin tests, the timeframe between place and read date must be at least two weeks, and time between placed dates must be at last 6 months

PPD #1 Plant Date: _____/_____/_____ PPD Read Date: _____/_____/_____ Read (in mm size): _____

PPD #2 Plant Date: _____/_____/_____ PPD Read Date: _____/_____/_____ Read (in mm size): _____

If PPD is positive, current documentation of inactive disease by chest x-ray on or after the date of the positive PPD/QuantiFERON-TB Gold Plus test is required.

Chest X-ray Date: _____/_____/_____ Chest X-ray Result: _____/_____/_____ Treatment Dates (if applicable): _____

OR QuantiFERON-TB Gold Plus Date: _____/_____/_____ Result: _____

FLU Vaccine: Date: _____/_____/_____

COVID Vaccine Dates #1 _____/_____/_____ #2 _____/_____/_____

Most Recent Booster _____/_____/_____

- Annual FLU shot must be within the current season Aug-April
- Most resent COVID booster if required by CDC (requirements subject to change per CDC or RIDOH)

Medical Physical exam: I hereby certify that this student is in good health and able to participate in all clinical activities without limitations.

Health Care Provider Signature: _____

Provider Printed Name: _____ Phone: _____/Fax_____

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