Immunization History Form

(To be completed by Health Care Provider)

January 2020
Volunteer Services

Program Name: **Duke Regional Hospital Junior Volunteer**

Dates of Program: **June 15 – August 7, 2020**

Parents/Legal Guardians: Complete this section and give this form to your child's health care provider.

Participant Name:_____

Participant Date of Birth: _____

Health Care Provider: Please provide the following immunization history information for Participant. An attached provider form with an official stamp and an authorized signature will also be accepted.

REQUIRED IMMUNIZATIONS

Immunization Name	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY	MM/DD/YYYY
DTaP/DTP/Td (at least 3 doses of tetanus required. Tdap required after age 12)				
Tdap				
MMR (Measles, Mumps, Rubella) 2 MMR vaccines required on or after first birthday **OR** positive titers (lab reports must be attached) **OR**				
Measles (single antigen 2 required on or after first birthday)				
Mumps (single antigen 2 required on or after first birthday)				
Rubella (single antigen 1 required on or after first birthday)				
Hepatitis B (The state of NC does not accept titers for this requirement. Designate vaccine type and list dates below.)				
Engerix-B (3 doses required) OR				
Heplisav-B (2 doses required)				
Meningococcal ACWY (Required after age 12. Booster required after age 16)				
Varicella (chickenpox)				
Varicella vaccine (2 doses required) OR				
Varicella IgG positive titer (lab report must be attached)				
Polio (at least 3 doses required)				
TB Test (within past 90 days)				
TB Test Read (with negative result)				

Name of Licensed Provider (please print): _____

Signature: _____

Title of Practice: _____

Office Address _____
Street

City _____ State _____ Zip Code _____

Telephone: (_____) _____ Date: _____