MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE

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DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*

Student Extern - Immunizations

Influenza (seasonal)

#1 ☐☐ - ☐☐ - ☐☐

Hepatitis B – Three doses; at least the first dose of the series is required prior to the student externship
OR lab report proving immunity

#1 ☐☐ - ☐☐ - ☐☐ #2 ☐☐ - ☐☐ - ☐☐ #3 ☐☐ - ☐☐ - ☐☐

Positive Hepatitis B antibody serology test date: _____ **Please attach lab report.**

Twinrix (Hepatitis A/B combination) – Three doses; at least the first dose of the series is required prior to the student externship (Twinrix is **not required** if the independent Hepatitis A series and Hepatitis B series have been given.)

#1 ☐☐ - ☐☐ - ☐☐ #2 ☐☐ - ☐☐ - ☐☐ #3 ☐☐ - ☐☐ - ☐☐

Measles, Mumps, Rubella (MMR) – Required: two doses
OR lab reports proving immunity

#1 ☐☐ - ☐☐ - ☐☐ (After one year of age) #2 ☐☐ - ☐☐ - ☐☐ (at least 1 month after first dose)

Date of MMR serology: _____ Please attach lab report. Circle immunity status below

Measles titer: immune / not immune **Mumps titer:** immune / not immune **Rubella titer:** immune / not immune

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name – last, first, middle; ID NUMBER or Social Security Number; Gender; Date of Birth; Rank/Grade.)*	REGISTER NUMBER	WARD NUMBER

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Polio – Required: one dose IPV within one year prior to the student externship (Adult dose required for INTERNATIONAL TRAVEL)

☐☐ - ☐☐ - ☐☐

Please document childhood series:

#1 ☐☐ - ☐☐ - ☐☐ #2 ☐☐ - ☐☐ - ☐☐ #3 ☐☐ - ☐☐ - ☐☐

#4 ☐☐ - ☐☐ - ☐☐ #5 ☐☐ - ☐☐ - ☐☐ #6 ☐☐ - ☐☐ - ☐☐

Tetanus, Diphtheria, Pertussis – Required: one dose Tdap

Tdap ☐☐ - ☐☐ - ☐☐

Please document childhood series:

#1 ☐☐ - ☐☐ - ☐☐ #2 ☐☐ - ☐☐ - ☐☐ #3 ☐☐ - ☐☐ - ☐☐

#4 ☐☐ - ☐☐ - ☐☐ #5 ☐☐ - ☐☐ - ☐☐ #6 ☐☐ - ☐☐ - ☐☐

Varicella (Chickenpox) – Required: two doses OR lab report proving immunity

#1 ☐☐ - ☐☐ - ☐☐ (After one year of age) #2 ☐☐ - ☐☐ - ☐☐ (at least 1 month after first dose)

History of Chickenpox? YES / NO Date of Varicella serology: _____ Please attach lab report.

Circle immunity status for **Varicella titer**: Immune / not immune

Tuberculin Skin Test – Circle vaccine type**: TST or Quantiferon Test**

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#1 ☐☐ - ☐☐ - ☐☐ #2 ☐☐ - ☐☐ - ☐☐

Skin Test Results _____ **mm** **Skin Test Results** _____ **mm**
Blood Test Results _____ **Blood Test Results** _____

If Reactive, was chest X-RAY obtained? YES NO (circle one) If yes, Date of X-RAY _____
Please provide X-Ray report.
Date, type and duration of prophylactic therapy, if applicable: _____
_____

I attest that the patient is currently free from blood-borne and respiratory communicable diseases.

HEALTH CARE PROVIDER INFORMATION

Signature: _____ **Date:** _____

Name (print or use stamp): _____

Mailing Address: _____

City, ST, ZIP: _____

Phone: _____ **Fax:** _____

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