HEALTH IMMUNIZATION FORM
Western Technical College (revised Feb 2018)

- THIS FORM MUST BE SIGNED BY A HEALTHCARE PROFESSIONAL (PHYSICIAN, NURSE PRACTITIONER, PHYSICIAN ASSISTANT, NURSE OR MEDICAL ASSISTANT).
- NURSING ASSISTANT STUDENTS ARE ONLY REQUIRED TO COMPLETE THE TUBERCULOSIS (TB) SKIN TEST.
- All other health/education programs are required to complete the entire form. Understand that the clinical sites or other agencies may require additional immunizations or titers. You will be contacted if this applies to your placement.

Western uses the current Center for Disease Control and Prevention (CDC) guidelines to determine the acceptability of documentation for proof of immunization.

PATIENT INFORMATION

NAME_______________________________________ DATE OF BIRTH _________________ PROGRAM________________

MMR VACCINE
(MEASLES (RUBEOLA) / MUMPS / RUBELLA)

Date of Vaccines   #1_________________

#2_________________

OR

Dates of Titer

Measles (Rubeola) Titer ________________________________ Immune / Non-Immune

Mumps Titer ________________________________ Immune / Non-Immune

Rubella Titer_______________________________ Immune / Non-Immune

If born before 1957:

a) Proof of immunity for Measles, Mumps & Rubella via documentation of disease in medical record or titres

b) 2 doses of vaccine to satisfy requirements for Measles; 2 doses of vaccine to satisfy requirements for Mumps; 1 dose of vaccine to satisfy requirement for Rubella

TB SKIN TEST (required annually)

Two consecutive annual tests between 10 and 12 months apart. Please note that the second test must not exceed 365 days from when the last one was administered.

Current Year Read Date: ________ Initials ________ Negative / Positive

Previous Year Read Date: ________ Initials________ Negative / Positive

If you do not have 2 consecutive current skin tests, a two-step is needed. Test dates must be 7-21 days apart.

Step 1 Test Date: ______________  Read Date_________

Step 1 Results:_______Negative/Positive   _________Initials

Step 2 Test Date:_______________ Read Date___________

Step 2 Results: ______Negative/Positive  _________Initials

If you have a positive TB test or have a documented history of a positive TB test:

• A negative chest x-ray report must be provided

• You must provide annual documentation that you are free of communicable disease

• Contact Enrollment Services at 608.789.6138 for special instructions

If your chest x-ray is positive for TB, proof of treatment is required.

Signature of Healthcare Provider ___________________________________________________________

Printed Name and Title                  Date ____________________________________________

SUBMIT ALL DOCUMENTATION TO: Western Technical College, Enrollment Services-Student Immunization Records,
400 Seventh Street North, PO Box C-0908, La Crosse WI  54602-0908
Fax 608-785-9148For questions call 608-785-9200 or 1-800-322-9982, ext.59553
HEALTH IMMUNIZATION FORM
Western Technical College (revised Feb 2018)

TO THE STUDENT:
All programs have affiliation agreements with agencies which require verification of compliance with the employee health standards. In many programs, these experiences begin within the first two weeks of school.

The form (BOTH SIDES) must be filled out completely.

PLEASE KEEP A COPY OF THIS RECORD FOR YOUR FILES.

Name____________________________________________

(Previous Name)_________________________________

Address________________________________________
________________________________________________

HEPATITIS B VACCINE
Date of Vaccines
#1_______________ #2______________ #3_____________
OR
Hepatitis B Titer_____________ Immune / Non-Immune
(Attach copies of lab results)             (Circle one)
OR
Signed Declination Statement below:
I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B Virus (HBV) infection. I decline the vaccination at this time. I understand that by declining the Hepatitis B vaccine I continue to be at risk of acquiring Hepatitis B as a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at that time.

______________________________________________
Student Signature                                                        Date

Student ID or SS # ____________________________________

Program Title _______________________________________

Date of Birth _______________________________________

Phone (Day) ______________________ (eve)_________________

VARICELLA (CHICKEN POX)
Date of Vaccines #1___________ #2____________
OR
Varicella Titer _____________________ Immune / Non-Immune
(Attach copies of lab results)               (Circle one)
OR
Verified history of Chicken Pox Disease
If yes, Date: ______________

TETANUS / DIPHTHERIA (TD)
OR
TETANUS,DIPHTHERIA,ACCELLULAR PERTUSSIS (TDaP)
TD or TDaP is required every 10 years

Date _____________________ TD / TDaP (circle one)

_____________________________________
Printed Name and Title                  Date

Signature of Healthcare Provider  

SUBMIT ALL DOCUMENTATION TO: Western Technical College, Enrollment Services-Student Immunization Records,
400 Seventh Street North, PO Box C-0908, La Crosse WI  54602-0908
Fax 608-785-9148For questions call 608-785-9200 or 1-800-322-9982, ext.59553