neighborcare health

(formerly Puget Sound Neighborhood Health Centers)
905 Spruce Street, #300
Seattle, WA 98104

NEIGHBORCARE HEALTH IMMUNIZATION RECORD

NAME:________________________________ DATE OF BIRTH________________

HOME ADDRESS:________________________ SSN:_____________________

POSITION: ____________________________ SITE:____________________

REQUIRED IMMUNIZATIONS. Please provide proof of documentation

HEPATITIS B: Required for all individuals. Document previous 3 dose series or serologic evidence of immunity upon rotation, or receive a 3 dose series and a titer at 1-6 months post 3rd dose.

Dates of Vaccination: 1) ____________ 2)______________ 3) ______________ **AND/OR**
Date of Serology: _________________ Result: __________________

REQUIRED TEST. Please provide proof of documentation

TUBERCULIN SKIN TEST (PPD/MANTOUX) Required upon rotation. 1 every 12 months
Date of Last Test: ____________ Result _________mm PPD Baseline #1 ____________ Result___________ mm
Chest X-Ray Date ____________ Result_________ PPD Baseline#2 ____________ Result___________ mm

RECOMMENDED IMMUNIZATIONS

MEASLES/MUMPS/RUBELLA: Required for all individuals born 1957 or later. Two doses of measles vaccines at or after one year of age **AND** administered after 1967. Individuals born prior to 1957 are not required to demonstrate proof, but are encouraged to do so if they are uncertain about their history.
Born prior to 1957? (Circle one) **YES** **NO** (If yes, no immunization or titer is required)

Dates of Vaccination(MMR/Measles) 1) _______________ 2)_________________ **AND/OR**

Date of Serology _________________ Result ____________________

VARICELLA: Required for all individuals who work in patient care areas.
Have you had chicken pox? (Please circle) **YES** **NO** If "yes", Approximate date of disease: ___________

If "No", indicate Immunization dates 1) _________ 2)________ AND/OR Date of Serology_________ Result _______

TETANUS/DIPTHERIA/PERTUSSIS (Td/Tdap): 1 booster every 10 years
Date of Last Dose__________________

INFLUENZA (TIV): Recommended for all individuals who work in patient care areas. 1 every 12 months
Date of Vaccination: _____________

I CERTIFY THAT THE ABOVE IS TRUE ______________________________ ______________
Signature **Date**

Reviewed by AMD/ADD: ______________________________ **Date**______________