HEALTH EXAMINATION BY PHYSICIAN

PART 2

Name of applicant _____

II. Please provide dates of either immunization or proof of immunity of the following:

	Proof of Immunity (Titer) or Date of Immunization/s
Measles (rubeola) • 2 live vaccinations after 1st birthday	
Mumps • 2 live vaccinations after 1st birthday	
Rubella (German Measles) • 1 live vaccination after 1st birthday	
T-DAP	
Varicella (Chicken Pox) • 2 vaccinations (or titer if history of disease)	

** If you were given the immunization prior to 1975 you may wish to protect yourself by having the immunization repeated.*
** Some clinical affiliates may ask for a titer.*

Return to student for document upload

Revised: March 2021