Standard Vaccine Form

For Respiratory Therapy Technology Program

Name of Applicant Date of Birth

Vaccine Form: Must be completed and initialed by a physician or trained medical personnel under the supervision of a physician.

Has the applicant had:				**Initials**
Rubella Vaccine				
	Yes	Date(s) of immunization:		
	A titre is required regardless of immunization status	**Date of titre:**		
Measles (Rubeola) Vaccine				
	Yes	Record dates of 2 live immunizations after 1st birthday		
	No/Unknown	Titre required Date of titre:		
Mumps Vaccine				
	Yes	Record dates of 2 live immunizations after 1st birthday		
	No/Unknown	Titre required Date of titre:		

Has the applicant had: **Initials**

Polio Vaccine				
	Yes	Date of immunization:		
	No/Unknown	Titre required Date of titre:		
Chickenpox (Varicella)				
	Vaccine	Date of immunization:		
	Illness	Date of illness required (if applicable):		
Tdap Vaccine Within Last 7 Years				
	Yes	Date of immunization:		
	No/Unknown	Booster required – record date:		

I certify that I am a licensed physician or work directly with a licensed physician.

Print Name _____

Office Address _____

Telephone _____

_____

Signature *Date of Examination*

*****Cost of the physical examination, laboratory tests and immunizations assumed by applicant. *****

Students: Submit this completed form to the Student Upload Portal found on the Respiratory Therapy webpage.