

Student Observer Name _____

HEALTH SCREENING DOCUMENTATION

Influenza Vaccination

Influenza Vaccination **within the current or immediate past season**

Date: _____

Did you receive your influenza vaccine at PAMC (Providence Alaska Medical Center)?

☐ Yes

☐ No

COVID-19 Vaccinations

COVID-19 Vaccinations (1st & 2nd)

Date: _____

Date: _____

Hepatitis B Vaccinations

Hepatitis B Vaccination (1st, 2nd, & 3rd)

Date: _____

Date: _____

Date: _____

OR

Hepatitis B Titer Showing Immunity

Date: _____

TDAP Vaccination

TDAP (Tetanus, Diphtheria, and Pertussis) Vaccination **within past 10 years**

Date: _____

MMR Vaccinations

MMR (Measles, Mumps, Rubella) Vaccination (1st & 2nd)

Date: _____

Date: _____

OR

MMR Titer Showing Immunity

Date: _____

Varicella Vaccinations

Chicken Pox (Varicella) Vaccination (1st & 2nd)

Date: _____

Date: _____

OR

Varicella Titer Showing Immunity

Date: _____

TB Tests

TWO (2) Non-reactive TB Skin Test Results (0 mm PPD) (1st & 2nd) within the past 12 months

Date: _____

Date: _____

OR

Negative QuantiFERON-TB Gold Blood Test **Result within the past 12 months**

Date: _____

OR

Negative T-SPOT Blood Test **Result within the past 12 months**

Date: _____

OR

If positive TB test; medical clearance, including x-ray result

Date: _____

Printed name of School Nurse or Health Care Provider _____

Date _____

Signature of School Nurse or Health Care Provider _____

If you have printed copies of your health records from your health care provider's office or the health department, those may be accepted in place of the signature, as long as all elements are included.