COLUMBIA STATE COMMUNITY COLLEGE

Immunity Verification Form
EMS Academy – Paramedic
Phone: (931) 540-2849 Fax: (931) 560-4103
Email: healthrecords@columbiastate.edu

Please Print
Name of Student: _____ Date: _____

Student ID: _____ Date of Birth: _____ Phone: _____

NOTE: Attach all Lab and Radiology Reports to this form.
2-Step TB SKIN TESTING (required)

Date Administered: _____ Date Read: _____ Result: _____ Sign-off: _____

Date Administered: _____ Date Read: _____ Result: _____ Sign-off: _____
NOTE: Must be within 6 months of starting clinical.

CHEST X-RAY only if TB positive
NOTE: If T.B. skin test is positive, you must submit a chest X-ray report. Date: _____ Result: _____

Please provide proof of MMR, Varicella, and Hepatitis B immunization either by Titer/IGG lab or by immunization records.
MMR (required)
Dates of 2 MMR Immunizations: Date #1_____ Date #2_____
(Also required if Titers show Not Immune or Equivocal)
OR
DATE of Titer/IGG for Rubeola: _____ Mumps: _____ Rubella: _____

RESULT of Titer/IGG for Rubeola: _____ Mumps: _____ Rubella: _____

VARICELLA ZOSTER (required)
Dates of 2 Varicella Zoster Immunizations: Date #1_____ Date #2_____
(Also required if Titers show Not Immune or Equivocal)
Have you ever had chicken pox? If YES, provide date: _____ NO: _____
OR
DATE of Titer/IGG for Varicella Zoster: _____ RESULT of Titer/IGG for Varicella Zoster: _____

HEPATITIS B (required)
Date of Hepatitis B series (received): #1_____ #2_____ #3_____ **AND**

DATE of Hepatitis B Surface Antibody: _____ RESULT of Hepatitis B Surface Antibody: _____
(After completion of series)(Lab report must be attached)

INFLUENZA (required for Fall/Spring students)
Date of Seasonal Influenza Immunizations (due Sept 24th for Fall students, due NOW for Spring Students): _____

TDAP (required) Date: _____ ***You must have a booster if your vaccination is over ten years old.***

_____, M.D. _____
Physician's /Provider's Signature Date

_____, M.D. _____
Print or type Physician's/Provider's Name Physician's/Providers Address

PLEASE sign off on any readings, immunizations, titers, after original signature. _____
Signature Date