Fannin County Fire Rescue and EMS

Emergency Medical Services Education Program

Student Immunization Record Form

NAME: _____ **PHONE:** _____ **BIRTH DATE:** _____

ADDRESS: _____ **CITY/STATE/ZIP CODE:** _____

I am a student in the Allied Health Department of North Georgia Technical College, and I authorize NGTC to release a copy of this form to clinical/practicum sites. I also understand that I must maintain a current record and will provide updated information as it is acquired.

Student's Signature _____ **Date:** _____

IMMUNIZATIONS: Please Attach Documentation

- € **See Attached**
- € **Diphtheria/Tetanus: __ /_/_ (Required within 10 years of program entry)**
  Signature of Person administering/ verifying _____
- € **MMR Vaccine: 1st vaccination __/__/__ 2nd vaccination __/__/__**
  Signature of Person administering / verifying _____
- € **Varicella (Chicken pox): __ Had Disease__ Had Vaccine__ Neither**
  NOTE: Varicella immunity is not required, but history is needed for consideration of assignments.
  Signature of Person administering/ verifying _____
- € **Hepatitis A series: 1st vaccination __/__/__ 2nd vaccination __/__/__**
  Signature of Person administering/ verifying _____
- € **Flu vaccination (seasonally required for clinical participation) ___ /___ / ___**
  Signature of Person administering/ verifying _____ _
- € **Mantoux Tuberculin Skin Test - PPD required before beginning program lab courses or clinical. Must be current yearly and last throughout completion of clinical courses.**
  Date Given: __/__/__
  Signature of Person administering _____
  Date Read: __/__/__ ___Negative ___Positive
  Signature of Person reading _____
  Second-Step Date Given: __/__/__
  Signature of Person administering _____
  Date Read: __/__/__ ___Negative ___Positive
  Signature of Person reading _____
- € **Covid vaccination 1st Dose: Manufacturer:** _____ **Date Given:**_____ **Site Given:**_____
  2nd Dose (if applicable): Manufacturer:_____ **Date Given:**_____ **Site Given:**_____
  Booster (if applicable): Manufacturer: _____**Date Given:** _____ **Site Given:** _____
- € **Hepatitis B Vaccine - Have you had the Hepatitis B Vaccine or are you currently receiving it? ___Yes ___No**
  (Please attach documentation)
  If YES, date(s): 1st vaccination__/__/__ 2nd vaccination __/__/__ 3rd vaccination __/__/__
  Hepatitis Titer: ___/___/___ Results _____
- € **THE HEPATITIS 8 VACCINE IS RECOMMENDED TO PROTECT THE STUDENT FROM POTENTIAL RISK. WAIVER:**
  I have been informed and understand the risks and the benefits to the Hepatitis B Vaccine and request that it not be given to me.
  Signature of Student _____ **Date** _____

- € **Health History: Can be completed by student. Check all that apply.**
- € **Asthma/ Allergies**
- € **Cardiovascular Disease**
- € **Head, Spinal, Back Injury**
- € **Kidney Disease**
- € **Permanent Defect/ Illness/ Injury**
- € **Rheumatic Fever**
- € **Seizures, Convulsions, Fainting**
- € **Sexually Transmitted Diseases**
- € **Thyroid Disease**
- € **Tuberculosis and or respiratory disorders**
- € **Menstrual disorders (Last pap smear) _____**
- € **History of mental health disorders**
- € **History of other serious defect, condition, illness, injury, or surgery_____**
- € **Immunodeficiency Disorder_____**