

Shadow Participant Immunization Checklist



Participants **MUST** attach Immunization Records as clinical documentation of each required vaccination

Name: _____ Date of Birth: _____

Allergies: _____

ECU Health – Review of Signs/Symptoms of Tuberculosis

(Circle appropriate responses)

Have you had a TB test in the past 12 months? YES NO

(If YES, please indicate results) Results: _____

Do you currently have:	1. Unexplained productive cough?	YES	NO
	2. Unexplained weight loss?	YES	NO
	3. Unexplained appetite loss?	YES	NO
	4. Unexplained fever?	YES	NO
	5. Night sweats?	YES	NO
	6. Shortness of breath?	YES	NO
	7. Chest pain?	YES	NO
	8. Increased fatigue?	YES	NO

Please explain any “YES” answers

Flu Vaccine *(during current seasonal year)*

Date Received _____ (mm/dd/yyyy) Vaccine Type: _____

Administered by _____ Location/Practice: _____

Varicella Vaccine *(or positive titer results)*

Two doses of vaccine will be needed for those with negative titers.

#1 _____ (mm/dd/yyyy) #2 _____ (mm/dd/yyyy) OR Positive Titer Results: _____ Date: _____ (mm/dd/yyyy)

MMR Vaccine (or individual Measles, Mumps, Rubella immunizations)

MMR (2 doses MMR (combination of Measles, Mumps, & Rubella) vaccine if administered in place of individual vaccines)

Two doses

#1_____ (mm/dd/yyyy) #2_____ (mm/dd/yyyy)

OR individual vaccines below:

Rubella Vaccine (or positive titer)

1 dose after the first birthday or Positive Titer

#1_____ (mm/dd/yyyy) OR Positive Titer Results:_____ Date:_____ (mm/dd/yyyy)

Rubeola Vaccine (Measles) (or positive titer)

2 doses after the first birthday or Positive Titer

#1_____ (mm/dd/yyyy) #2_____ (mm/dd/yyyy) OR Positive Titer Results:_____ Date:_____ (mm/dd/yyyy)

Mumps Vaccine (or positive titer)

2 doses after the first birthday or Positive Titer

#1_____ (mm/dd/yyyy) #2_____ (mm/dd/yyyy) OR Positive Titer Results:_____ Date:_____ (mm/dd/yyyy)

Tdap Vaccine

1 dose Tdap (Adacel)

Tdap_____ (mm/dd/yyyy)

The above health statement checklist is accurate to the best of my knowledge. I have provided immunization/vaccination records to document each vaccination listed. I will see my primary physician and/or the health department if my health status changes.

Signature

Date