Shadow Participant Immunization Checklist

ECU HEALTH

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