WillsEye Hospital

America's First World's Best

Volunteer/International Visitor Immunization Documentation

Name (print): ______________________________ DOB: _____________

The following information is required. _All documentation must be in English._

To be filled out by applicant's Physician or Nurse Practitioner:
***Any titers reported must also submit a copy of the laboratory test(s) and result(s) IN ENGLISH*

Chicken Pox/Varicella: Proof of immunity will mean two doses of varicella OR serologic evidence of immunity. History of disease is not accepted.

Immunization: Date 1: __________ Date 2: __________
Titer Date: _____________ Result:☐ Immune ☐ Not Immune

Rubella: Proof of immunity to German measles will mean one dose of the rubella vaccine OR serology.

Immunization Date: ___________________
Titer Date: _____________ Result:☐ Immune ☐ Not Immune

Rubeola: Proof of immunity to measles will mean two doses of live vaccine (after 1968) administered on or after the first birthday, separated by at lease one month OR serological evidence of immunity.

Immunization Date: #1: ____________ #2: ____________
Titer Date: ____________ Result: ☐ Immune ☐ Not

Mumps: Proof of mumps immunity will mean two doses of mumps vaccine administered on or after the first birthday OR serologic evidence of immunity.

Immunization Date: #1: ____________ #2: ____________
Titer Date: ____________ Result: ☐ Immune ☐ Not Immune

Influenza: Proof of vaccination from current/most recent season.

Immunization Date: ____________ Manufacturer: __________
Lot #:____________ Exp Date: ______________

Pertussis: Proof of immunity means documentation of the Tdap vaccine (tetanus, diptheria, pertussis, or ADACEL).

Immunization Date: _____________(must be post 2005)

Hepatitis B: Immunization Date 1: __________ Date 2: __________ Date 3: __________
AND HBsAB titer Date: ____________ Result: ☐ Immune ☐ Not Immune

Tuberculosis Screen: IGRA (Interferon-Gamma Release Assays) blood test is required.

Date: _________________ (must be within 3 months)
Result ☐ Positive ☐ Negative ☐ Indeterminate (report IN ENGLISH must be attached)
If IGRA is positive or indeterminate, a chest x-ray (CXR) is required.
CXR date:__________ (must be within 6 months; attach a copy of the report, in English)

MD/CRNP: ______________________________ (signature) Phone #: ( ) _________________

MD/CRNP: ______________________________ (print) Date: ________________________

Address: ____

Updated 2/2014
Murchison