



**HEALTH RECORD VERIFICATION
FOR OBSERVATION/SHADOWING REQUESTS**

Name _____

Address _____

Phone _____

Affiliated with (Agency/School) _____

TO BE VERIFIED AND DOCUMENTED BY A HEALTH CARE PROVIDER

1) **Tuberculosis screening** within 12 months: Date _____ Results _____

2) **Measles, Mumps, Rubella**

- Written statement of positive from a health care provider
- "Positive" MMR titers documentation Date _____
- Documentation of 2 MMR's
 - (1) Age _____ Date _____
 - (2) Age _____ Date _____

3) **Chicken Pox (Varicella)**

- Written statement of positive history from a health care provider
- "Positive" varicella titer documentation Date _____
- Documentation of 2 immunizations
 - (1) Age _____ Date _____
 - (2) Age _____ Date _____

4) **Tetanus Toxoid, Diphtheria and Pertussis**

- Documentation of one booster dose of Tdap vaccine within last 10 days.
Date given _____

5) **Transmissible Infections:** student states no known infection/illness as of
Date _____

6) **Seasonal Flu vaccination received** Date _____

Completed by _____ Date _____

Agency _____ Phone _____

Address _____