IMMUNIZATION FORM – ALLIED HEALTH PROGRAMS

STUDENT NAME: _______________________________ STUDENT ID __________________

PROGRAM: ________________________________________

TETANUS

Date Received: _______________________________

VARICELLA VACCINE OR TITER

Date of Immunization/Disease: ______________________
Date of Titer: _______________________________ Results: ________________

MMR VACCINATIONS

MMR #1 (Date): _______________________________

MMR #2 (Date): _______________________________

Students are required to have a Rubella and Measles Titer (laboratory evidence of immunity) indicating immune status.

Health Care Provider Signature: ___________________________ Date _____________

Health Care Provider Printed Name: _________________________________

Health Care Provider Contact Information: _______________________________

Complete and forward to any Student Services Center:

Burlington Center
496 McCanna Pkwy
Burlington, WI 53105

Elkhorn Campus
400 County Road H
Elkhorn, WI 53121

Kenosha Campus
3520 - 30th Avenue
Kenosha, WI 53144

Racine Campus
1001 S. Main Street
Racine, WI 53403

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