Emergency Medical Technician Immunization Record

Name_____
Last Name First Name Middle Name Phone Number

Permanent Address _____
Street City State Zip Code

To be completed and signed by your health care provider or please attach official immunization record.

REQUIRED:

Hepatitis B (Three doses of vaccine or a positive Hepatitis surface antibody)

Immunization
a. Dose #1___/___ b. Dose #2___/___ c. Dose #3___/___ or
M Y M Y M Y
b. Hepatitis B surface antibody (titer should only be drawn after vaccine series or exposure)
Date ___/___ Result Reactive_____ Non-reactive_____
M Y

Tuberculosis Skin Test, within the last 12 months: Date:___/___/___ Result:_____
(Example: PPD, tine)
If positive PPD, when was your Chest X-ray? **Date:___/___/___ Result:_____**

RECOMMENDED:

Tetanus-Diphtheria (Primary series with DTaP or DTP and booster with Td in the last ten years) 1. Primary series of four doses with DtaP or DTP:
#1 ___/___ #2 ___/___ #3 ___/___ #4 ___/___
M Y M Y M Y M Y
Tetanus-Diphtheria (Td) booster within the last ten years …….___/___
M Y

Measles, Mumps, Rubella: Two MMR vaccinations, or adequate immune titer:
Immunization
a. Dose #1___/___ b. Dose #2___/___
M Y M Y
b. MMR Titer(antibody titer test to check for immunity to Measles/Rubeola, Mumps, and Rubella)
Titer Date ___/___ Titer Result _____
M Y

Health Care Provider
Name_____ Address_____

Signature_____ Phone _____

Immunization Waiver
Due to medical, religious, or personal reasons, I choose to decline immunization.

Student name (printed) _____

Student signature: _____ Date: _____

Please return form to:
NIC Workforce Training Center
525 S. Clearwater Loop, Post Falls, Idaho 83854
Fax (208) 769-3224
Phone (208) 769-3214