

B-ESD EMPLOYEE IMMUNIZATION HISTORY (MMR, Tdap)

Last Name:		First Name:		M.I.	
DOB:		Street Address:			
City:				State:	
Phone:		Email:			

MMR (Measles, Mumps, Rubella) - Two (2) doses of MMR vaccine or two (2) of Mumps and one (1) dose of Rubella; or serologic proof of immunity for Measles, Mumps and/or Rubella. Choose only one option. Note: a 3rd dose of MMR vaccine may be advised during regional outbreaks of measles or mumps if original MMR vaccination was received in childhood.					Copy Attached
Option 1	Vaccine	Date			
MMR - 2 doses of MMR vaccine	MMR Dose #1				<input type="checkbox"/>
	MMR Dose #2				
Option 2	Vaccine or Test	Date			
Measles - 2 doses of vaccine or positive serology	Measles Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Measles Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Qualitative Titer Results:	___ IU/ml	
Mumps - 2 doses of vaccine or positive serology	Mumps Vaccine Dose #1		Serology Results		<input type="checkbox"/>
	Mumps Vaccine Dose #2		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Qualitative Titer Results:	___ IU/ml	
Rubella - 1 dose of vaccine or positive serology		Date	Serology Results		<input type="checkbox"/>
	Rubella Vaccine		Qualitative Titer Results:	<input type="checkbox"/> Positive <input type="checkbox"/> Negative	
	Serologic Immunity (IgG antibody titer)		Qualitative Titer Results:	___ IU/ml	

Tetanus-diphtheria-pertussis - 1 dose of adult Tdap; if last Tdap is more than 10 years old, provide date of last Td or Tdap booster					Copy Attached
	Vaccine	Date			
	Tdap Vaccine (Adacel, Boostrix, etc.)				<input type="checkbox"/>
	Td Vaccine or Tdap Vaccine booster (if more than 10 years since last Tdap)				<input type="checkbox"/>

Exemption: In the event of an outbreak of vaccine preventable disease from which you are exempt, you may be excluded from work for the duration of the outbreak.

- ☐ Religious
☐ Philosophical
☐ Medical Exemption

Signature: _____ Date: _____

I certify that the information provided above is correct.

Signature: _____

Date: _____