GREAT FALLS COLLEGE MSU
Student Immunization and Verification Form

Name _____ Male _____ Female _____ Date of Birth _____

Address _____ City _____ Zip _____

Program of Study: <u>RESPIRATORY THERAPY</u>_____ Phone # _____

Email Address:_____

IMMUNIZATIONS: <u>PLEASE LIST DATES</u>….

Measles, Mumps, Rubella _____ Tdap (within last 7-10 years)_____

Hepatitis B Series 1)_____ 2)_____ 3) _____ Titer_____
(Titer STRONGLY recommended by OSHA, CDC, and GFC MSU)

TB (Year 1- 2step required)   1) _____ 2) _____   positive/negative   Tine _____
PPD (if Year 2) Date completed _____

Varicella (Proof of Chicken Pox or Vaccination date) _____

Current Influenza _____Health Insurance_____

VERIFY THE FOLLOWING….

	YES	NO	Initials
Allergic to Latex or Latex products.			
CPR for Health Care Providers verification, completed and current upon admission: Online courses not accepted. (Photocopy of certification card, both sides, showing expiration and instructor's signature).			
I have attached proof of all immunizations or test results required.			

Requirement Details:

- MMR (Measles-Mumps-Rubella)
  - Requirements:
    - Vaccination - 2 Doses OR positive Blood Test / Titer
    - Negative Titer result requires vaccination
- Tdap
  - Requirements:
    - Vaccination - 1 Dose OR Booster accepted
    - Valid for - 10 years
- Hepatitis B
  - Requirements:
    - Vaccination - 3 Doses OR Blood Test / Titer
    - Negative Titer result requires vaccination
    - 2 doses minimum required to start
- Tuberculosis
  - Requirements:
    - Skin Test - 2 Step OR Blood Test / Titer OR proof of 2 consecutive years
    - Negative reactions require a Chest X-Ray with Absence of Symptoms Form
    - Valid for - 1 year, renewed yearly
- Varicella (Chickenpox)
  - Requirements:
    - Date of Illness OR Vaccination - 2 Dose OR positive Blood Test / Titer
    - Negative Titer result requires vaccination
- Influenza
  - Requirements:
    - Vaccination - 1 Dose per year, renewed yearly
    - Waiver Eligible
- Medical Insurance
  - Requirements:
    - Insurance Provider
    - ID/Policy Number
- CPR (Health Care Provider)
  - Requirements:
    - Must include Date Completed & Date Expires
- Background Check
  - Requirements:
    - MyClinicalExchange
- Drug Screen
  - Requirements:
    - MyClinicalExchange
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