# Florida Institute of Ultrasound, Inc
# Immunization Record

***FORM TO BE COMPLETED AND SIGNED BY HEALTHCARE PROVIDER***

**Name:** _____ DOB: _____

**Hepatitis B Vaccination** - Three (3) doses of vaccine or serologic immunity.

| | | **Date** | **Result** |
|---|---|---|---|
| Hepatitis | Hepatitis B vaccine dose #1 | ___/___/___ | |
| - 3 doses of vaccine or | Hepatitis B vaccine dose #2 | ___/___/___ | |
| serologic immunity (titer) | Hepatitis B vaccine dose #3 | ___/___/___ | |
| | Serologic Immunity (titer) | ___/___/___ | Immune/Non-Immune (circle results) |

**MMR (Measles, Mumps & Rubella)** - Two (2) doses of vaccine or serologic immunity.

| | | **Date** | **Result** |
|---|---|---|---|
| MMR | MMR vaccine dose #1 | ___/___/___ | |
| - 2 doses of vaccine or | MMR vaccine dose #2 | ___/___/___ | |
| serologic immunity (titer) | Serologic Immunity (titer) | ___/___/___ | Immune/Non-Immune (circle results) |

**Varicella (Chicken Pox)** - Two (2) doses of vaccine or serologic immunity.

| | | **Date** | **Result** |
|---|---|---|---|
| Varicella | Varicella vaccine dose #1 | ___/___/___ | |
| - 2 doses of vaccine or | Varicella vaccine dose #2 | ___/___/___ | |
| serologic immunity (titer) | Serologic Immunity (titer) | ___/___/___ | Immune/Non-Immune (circle results) |

**Tuberculosis Screening** - Results of TB/PPD test - within last twelve (12) months.

PPD Test Date: ___/___/___ Date & Time Administered: _____

Administered by: _____

Manufacture of PPD _____ Expiration Date: _____ Lot No.

Date Read ___/___/___ Read by _____

Results in Millimeters of Induration _____

**If results are positive or restricted from a PPD due to the BCG vaccine, a chest X-ray is required.**

Chest X-ray Date ___/___/___ Attach Results of Chest X-ray Examiner's Initials: _____

**Tetanus - Diphtheria - Pertussis** - One (1) dose of adult Tdap. If last Tdap is more than 10 years old, provide date of last Tdap.

Tdap vaccine Lot #: _____ Expires: ___/___/___ Date: ___/___/___

**Healthcare Provider Name & Address** _____ **Phone** _____

_____ **Fax** _____

_____

_____

**Healthcare Provider Authorized Signature** _____ **Date** ___/___/___