TCAT
UPPER CUMBERLAND

IMMUNIZATION RECORD

NAME_____ PIN NAME ☐☐☐☐☐

Use this form to report your immunizations. It must be signed by the health facility representative for it to be considered an official document. Copies of documentation should be stapled behind this form. Failure to complete and document this form may result in denial of entrance into the program. Any questions should be directed to:
Practical Nursing – Cynthia Tompkins-931-444-1328. Surgical Technology - Melissa Oakes, 931-444-1306.

CHECK APPROPRIATE BOX

MMR: MEASLES (Rubeola), **MUMPS**, & **RUBELLA** Must reflect 2 vaccinations since 1979 or proof of immunity; not required if born before 1957.

☐ Born before 1957 _____ Birth date
or
☐ Immunized with MMR twice (1) _____ Date (2) _____ Date
or
☐ Positive titer _____ Date

and

TETANUS – Needed every 10 years _____ Date

and

T.B. SKIN TEST – Required annually or chest x-ray _____ Date _____ Results

CHICKENPOX (1)_____ Date (2)_____ Date

and

HEPATITIS B – Highly recommended but optional at this time for PN; required for ST. This is to acknowledge that I have been informed by the TCAT staff of the risks of acquiring Hepatitis B due to the nature of my professional responsibilities in the program. I have also been informed of the benefits of receiving the vaccination for protection against Hepatitis B.

☐ Series of three (3) immunizations completed _____ Date _____ Date _____ Date
or
☐ In the process of receiving vaccination. List dates above of any received.
or
☐ Declines vaccination at this time.

☐ **FLU VACCINE (**for clinical**)**

_____ Healthcare Signature _____ Date

_____ Date _____ Signature of Health Facility Representative/Name of Facility

_____ Date _____ Signature of Applicant