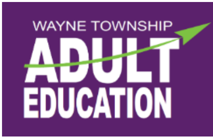

MSD Wayne Township- WTAE- Career Training
1155 S. High School Rd Door #2, Indianapolis, IN 46241

IMMUNIZATION RECORD

Program:

Patient Information:

NAME:____ **DOB:** ________________________

PHONE: _______________________ **EMAIL:** ____

ADDRESS: ____

CITY : __________________________**STATE:** __________________ **ZIP:** ________________________

Signature: ____

Signing this form gives permission to release this information to WTAE and its affiliates.

Important: Month/Day/Year REQUIRED

Measles/Mumps/Rubella	**Hepatitis B**	**Tetanus/Diphtheria/Pertussis** Within last 10 years	**Varicella**
MMR 1: \ \	**HBV 1:** \ \	**Date TDAP:** \ \	**Varivax 1:** \ \
MMR 2: \ \	**HBV 2:** \ \		**Varivax 2:** \ \
	HBV 3: \ \	**Series 1:** \ \	
		Series 2: \ \	**Influenza:** \ \ WITHIN 12 months
MMR Titer : Measles : Immune ❒ Not Immune ❒ Mumps: Immune ❒ Not Immune ❒ Rubella: Immune ❒ Not Immune ❒	**Hepatitis B Titer:** HBSAB: Immune ❒ Not Immune ❒	**TB Skin Test/ PPD** WITHIN 12 months Negative ❒ Positive ❒ Chest X-ray Complete ❒ Not Complete ❒	**Varicella Titer** Varicella: Immune ❒ Not Immune ❒

Physician Information: (Affix Physician Office Stamp if Available)

Office Name: ____ **Phone:** ________________________

Office Address: ____

Physician/Nurse Name: ____ **Credential/License:** _____________

SIGNATURE REQUIRED: ____ **Date:** _________________________