ASSURED NURSING
18725 N. Union St.
Westfield, IN 46074
Office: 317-862-8141
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Immunizations / Vaccines Form

Date	Employees Name	DOB	Phone

Full Address	Email

RECOMMENDED IMMUNIZATIONS AND TESTS: INFORMATION IS REQUIRED

Hepatitis B vaccine: The CDC STRONGLY RECOMMENDS hepatitis B vaccination (includes 3 vaccines and post-vaccine titer) for all health care professionals. A signed declination form must be completed if this applicant declines vaccine.

Varicella History: If no confirmed disease history, serological test is required. If negative, vaccination with 2 Varicella vaccines is strongly recommended. A signed declination form must be completed if the applicant declines vaccine.

Tetanus-Diphtheria (initial series and booster every 10 years) OR Tdap: The CDC recommends that health providers who have direct patient contact should receive a single dose of Tdap as soon as feasible if they have not previously received it

Hepatitis B - 3 Vaccines & Post Vaccine TITER

Immunization #1 Date: ____/____/____ Immunization #2 Date: ____/____/____ Immunization #3 Date: ____/____/____

Post-Vaccine Titer: Date: ____/____/____ Result: _____

***Declination**: I decline the Hepatitis B Vaccination at this time. I understand that by declining this vaccine, I continue to be at risk for acquiring Hepatitis B infection. In the future, if I continue to have occupational exposure to blood or potentially infectious materials and would like the Hepatitis B vaccine, I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow: _____ Date: ____/____/____

Varicella (Chicken Pox) *(check one)*

☐ Varicella vaccine: ____/____/____ **OR** ☐ Have had chicken pox **OR** ☐ Positive antibody titer: Date: ____/____/____

***Declination**: I decline the Varicella Vaccine and understand I am susceptible to chicken pox. I understand the risks of being susceptible to infections and blood borne diseases and decline immunization at this time. I understand I may choose to receive the vaccine at any time in the future.

Declination Signature of Intern/Resident/Fellow: _____ Date: ____/____/____

Tetanus-Diphtheria OR Tdap

Immunization ____/____/____ ☐ Td ☐ Tdap

MEASLES / MUMPS / RUBELLA (MMR)

MMR (Measles, Mumps, and Rubella): 1st Vaccine: ____/____/____ 2nd Vaccine: ____/____/____ **OR**

Measles Rubeola: 1st Vaccine Date: ____/____/____ 2nd Vaccine Date: ____/____/____ **OR** Positive Titer Date: ____/____/____

Born before 1/1/57 *(proof of immunization is required only for individuals born after 1/1/57)* Results: _____

Mumps: Vaccine Date: ____/____/____ **OR** Positive Titer: Date: ____/____/____ Results: _____

Rubella: Vaccine Date: ____/____/____ **OR** Positive Titer: Date: ____/____/____ Results: _____

Examining Practitioner's Signature_____ Date ____/____/____

Examining Practitioner's Printed Name _____

Examining Practitioner's Medical License # _____

Address _____

Phone (____) _____ Fax (____) _____ Email _____