

❖ **Chicken Pox (Varicella)** (Please check one of the following)

Have proof of adequate Varicella titer (*attach copy of titer lab results*)

Date: _____ Results: _____

Have **2 doses** of Varicella vaccine

Dates vaccinated: 1st _____ 2nd _____

❖ **Tetanus and Diphtheria (Tdap)**

Date: Initial _____ Most Recent Booster _____

**vaccination must be within the last 10 years*

❖ **Hepatitis B (HBV)** (Please check one of the following)

Have proof of adequate Hepatitis B titer (*attach copy of titer lab results*)

Date: _____ Results: _____

Have **3 doses** of Hepatitis B vaccine

Dates vaccinated:

#1 _____ #2 _____ #3 _____

Examiner's Signature

Examiner's Name (Print)

Date

Licensed as a (circle one): MD DO PA ARNP CNP CNM

License Number: _____ State/Country Licensed: _____

Telephone: () _____

Address:

Street

City

State

Zip

*** Attention Southeast Tech Student: Return this completed form to Clorinda Beitelspacher, Affiliate Coordinator located Health Science Center, Office HC200D, Fax 605-367-6108**