neighborcare health
(formerly Puget Sound Neighborhood Health Centers)
905 Spruce Street, #300
Seattle, WA 98104

NEIGHBORCARE HEALTH IMMUNIZATION RECORD

NAME:_____ DATE OF BIRTH_____

HOME ADDRESS:_____ SSN:_____

POSITION: _____ SITE:_____

REQUIRED IMMUNIZATIONS. Please provide proof of documentation

HEPATITIS B: Required for all individuals. Document previous 3 dose series or serologic evidence of immunity upon rotation, or receive a 3 dose series and a titer at 1-6 months post 3rd dose.

Dates of Vaccination: 1) _____ 2)_____ 3) _____ **AND/OR**
Date of Serology: _____ Result: _____

REQUIRED TEST. Please provide proof of documentation

TUBERCULIN SKIN TEST (PPD/MANTOUX) Required upon rotation. 1 every 12 months
Date of Last Test: _____ Result _____mm PPD Baseline #1 _____ Result_____ mm
Chest X-Ray Date _____ Result_____ PPD Baseline#2 _____ Result_____ mm

RECOMMENDED IMMUNIZATIONS

MEASLES/MUMPS/RUBELLA: Required for all individuals born 1957 or later. Two doses of measles vaccines at or after one year of age **AND** administered after 1967. Individuals born prior to 1957 are not required to demonstrate proof, but are encouraged to do so if they are uncertain about their history.
Born prior to 1957? (Circle one) **YES** **NO** (If yes, no immunization or titer is required)

Dates of Vaccination(MMR/Measles) 1) _____ 2)_____ **AND/OR**

Date of Serology _____ Result _____

VARICELLA: Required for all individuals who work in patient care areas.
Have you had chicken pox? (Please circle) **YES** **NO** If "yes", Approximate date of disease: _____

If "No", indicate Immunization dates 1) _____ 2)_____ AND/OR Date of Serology_____ Result _____

TETANUS/DIPTHERIA/PERTUSSIS (Td/Tdap): 1 booster every 10 years

Date of Last Dose_____

INFLUENZA (TIV): Recommended for all individuals who work in patient care areas. 1 every 12 months
Date of Vaccination: _____

I CERTIFY THAT THE ABOVE IS TRUE _____ _____
Signature **Date**

Reviewed by AMD/ADD: _____ **Date**_____