TITER / VACCINE RECORD

COLLEGE OF DUPAGE HEALTH SERVICES
425 FAWELL BLVD., GLEN ELLYN, ILLINOIS 60137
630-942-2154 tel / 630-942-2071 fax

Please Print

Name _____
Last **First**
Allied Health Program_____**Date of Birth** _____**SS#**_____

FOR REQUIRED TITER – ATTACH RELATED LABORATORY REPORTS

TITER (Must be IgG)	Rubella	Rubeola	Varicella	Mumps	HbsAb
Date Blood Drawn					

ADULT VACCINATION RECORD

	Date	Manufacturer Name	Lot #	Administered by	VIS * Date
Tetanus/Dip					
Hep B. #1					
Hep B. #2					
Hep B. #3					
MMR					
Varicella					

Previous Hepatitis B-Series? _____ **If documentation unavailable, please explain**
_____

_____

Previous positive TB test? Yes____ **No**____ **Date**_____ **Facility (if available)**
_____

Two Step TB test:

Step One: Date given_____ **R / L Time**_____ **Nurse**_____

Date read_____ **Results** _____**mm** **Nurse** _____

Step Two: Date given_____ **R / L Time**_____ **Nurse**_____

Date read_____ **Results** _____**mm** **Nurse**_____

Positive TB Test Referred for X-Ray to: _____

X-Ray Report following positive TB attached: Date _____ **Facility** _____

TB Update by: _____
Month/ Day/ Year

Doctor's Office Stamp-include Address & Phone

**Vaccine Information Sheet*

Medical Forms JJ 09