HUTCHINSON
REGIONAL MEDICAL CENTER

HEALTH RECORD VERIFICATION

FOR OBSERVATION/SHADOWING REQUESTS

Name_____

Address_____

Phone_____

Affiliated with (Agency/School)_____

TO BE VERIFIED AND DOCUMENTED BY A HEALTH CARE PROVIDER

1) **Tuberculosis screening** within 12 months: Date_____ Results_____

2) **Measles, Mumps, Rubella**
   - ❑ Written statement of positive from a health care provider
   - ❑ "Positive" MMR titers documentation Date _____
   - ❑ Documentation of 2 MMR's
     (1) Age_____ Date _____
     (2) Age_____ Date _____

3) **Chicken Pox (Varicella)**
   - ❑ Written statement of positive history from a health care provider
   - ❑ "Positive" varicella titer documentation Date _____
   - ❑ Documentation of 2 immunizations
     (1) Age _____ Date _____
     (2) Age _____ Date _____

4) **Tetanus Toxid, Diptheria and Pertussis**
   - ❑ Documentation of one booster dose of Tdap vaccine within last 10 years.
     Date given_____

5) **Transmissible Infections**: student states no known infection/illness as of
   Date_____

6) **Influenza vaccination**: Seasonal- October 1 thru March 31
   Date _____

Completed by_____ **Date**_____

Agency_____**Phone**_____

Address_____