Applicant Printed Name:
DOB:
Social Security Number:
Phone:

The following MUST be completed by a physician, physician's assistant, or nurse practitioner. Please use mm/dd/yyyy format for dates.

Measles (Rubeola)		
2 doses of measles vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: ______________	Date #2: _______________
Serologic test positive for measles antibody	Date: ______________	Result: _______________
Mumps		
2 doses of mumps vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: ______________	Date #2: _______________
Serologic test positive for mumps antibody	Date: ______________	Result: _______________
Rubella		
1 dose of Rubella vaccine on or after their 1st birthday	Date #1: ______________	Date #2: _______________
Serologic test positive for Rubella antibody	Date: ______________	Result: _______________
Varicella		
2 doses of varicella vaccine on or after their 1st birthday and at least 30 days apart OR	Date #1: ______________	Date #2: _______________
Serologic test positive for Varicella antibody OR	Date: ______________	Result: _______________
Physician documented history or diagnosis of Varicella	Date disease occurred: ______________________	
Tetanus, Diphtheria, Pertussis (Tdap)		
1 dose of TDaP vaccine within the last 10 years	Date: _______________	
Tuberculosis, Flu, and COVID-19 Vaccination Information		
Tuberculosis Blood Test: Must be completed **within 3 months prior** to starting to volunteer. Chest X-rays for positive blood test must be done within the last 90 days prior to starting to volunteer.	Date: ______________ **CXR Results for positive TB blood test:** Date: ______________	Type: ▢ Tspot **OR** ▢ QFT Result: ▢ Positive ▢ Negative Result: ▢ Positive ▢ Negative
Flu Vaccine (required during flu season)	Date: ______________	
COVID -19 Vaccines **Type:** ▢ **J&J** ▢ **Pfizer** ▢ **Moderna**	Date #1: ______________	Date #2: _______________

Physician or Approved Licensed Health Professional Information	
Printed Name: ______________________________ **Title:** ________	**Office/Clinic Stamp:**
Address: ________________________________**City:** _____________ **State:** _____ **Zip:** _________ **Phone:** _________________	
Signature: ____ **Date:** ________________	