Immunization Review Form

Name ________________________________ Date of Birth_____________ Age ________

Training Course_________________________ Period of Training __________ to _________

Profession _____________________________ Organization__________________________

PROOF OF IMMUNIZATIONS IS REQUIRED!!

This Required Immunization and Screening Form must be completed and returned to irqsnich@gmail.com

To prevent infection, QSNICH requires all personnel that have direct contact to take vaccinations of varicella, hepatitis B, measles, diphtheria and influenza. The immunization section must be completed and signed and you need to provide personal documentation of immunizations (vaccine history card, etc.)

Required Immunizations and Screenings

Infectious Diseases	History (Please circle where appropriate)	Antibodies		Date of Vaccinations (D/M/Y)
		Results	Date (D/M/Y)	
Varicella	Never infected/ Infected (years old) / Unknown	☐ Positive ☐ Borderline ☐ Negative		Dose 1 _____________ Dose 2_____________
Hepatitis B	Never infected/ Infected (years old) / Unknown	☐ Positive ☐ Borderline ☐ Negative		Dose 1 _____________ Dose 2 _____________ Dose 3_____________
Measles	Never infected/ Infected (years old) / Unknown	☐ Positive ☐ Borderline ☐ Negative		Dose 1_____________
Diphtheria	Never infected/ Infected (years old) / Unknown	☐ Positive ☐ Borderline ☐ Negative		Dose 1____________
Influenza	Never infected/ Infected (years old) / Unknown	☐ Positive ☐ Borderline ☐ Negative		Dose 1_____________

HAVE YOU HAD ANY OF THE FOLLOWING IN THE LAST MONTH? (Please check)

Fever	____Yes	____ No	**Cough (for >3 weeks)**	____Yes	____ No
Chills	____ Yes	____ No	**Weight Loss**	____Yes	____ No
Night Sweats	____ Yes	____ No	**Sputum Production**	____ Yes	____ No
Fatigue	____ Yes	____ No	**Blood in Sputum**	____Yes	____ No

Chest X-Ray: Normal /Abnormal (____)

Any other comments or information that we should know about your health: ______________________

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Please have this form filled in and signed below by your healthcare provider or you may complete the form and send scanned copies of valid documentation affixed to this form.

Name ____________________________________ **Title :** ______________________

Signature: ________________________________ **Date:** ______________________