Cooley Dickinson Hospital
Volunteer Department
Student Health Record

The Information requested on this form must be completed by your health care provider or College Health Services Representative. Once this form has been completed, please call Cooley Dickinson Hospital Employee Health Service, 413.582.2236, to schedule an appointment for your clearance.

FAILURE TO PROVIDE EVIDENCE OF ALL REQUIRED IMMUNIZATIONS WILL DELAY YOUR START TIME.

Name of Student:_____
Address:_____
Date of Birth:_____ **Telephone**_____
Assignment area:_____

OSHA CATEGORY 1_____YES_____NO

THE FOLLOWING IS TO BE COMPLETED BY THE HEALTH CARE PROVIDER OR COLLEGE HEALTH SERVICES REPRESENTATIVE:

1. **CURRENT TB SKIN TEST (TST) within 12 months and another within 3 months of today.**
   TB Test #1 Date:_____ Results:_____
   TB Test #2 Date:_____ Results:_____
   If TST is positive, report of chest x-ray completed since the positive skin test.
   Date of Chest x-ray:_____ Result:_____
2. **RUBEOLA (MEASLES) TITER**
   Date:_____**Result**_____**Interpretation** _____**Positive**_____**Negative**
   OR Date of Measles Vaccinations: #1_____**#2**_____
   NOTE: As of 1/29/1989, the CDC recommends TWO doses of measles vaccine for people entering medical facilities. Vaccinations given before 12 months of age are not acceptable. Measles vaccine prior to 1968 is only acceptable if live vaccine was used.
3. **RUBELLA (GERMAN MEASLES)TITER**
   Date:_____**Result**_____**Interpretation** _____**Positive** _____**Negative**
   OR Date of Rubella Vaccination: #1_____
4. **MUMPS TITER**
   Date:_____**Result**_____ **Interpretation** ____**Positive** ____**Negative**
   OR Dates of MMR Vacination: #1_____ **#2** _____
5. **VARICELLA (CHICKENPOX) TITER**
   Date:_____**Result**_____**Interpretation** ____**Positive** _____**Negative**
   OR Date of Varicella Vaccination: #1_____ **#2**_____
   *****NOTE: HAVING CHICKENPOX DOES NOT INFER IMMUNITY**
   REQUIREMENT: Documentation of two (2) vaccines OR a varicella titer

PLEASE COMPLETE BELOW ONLY FOR OSHA CATEGORY I POSITIONS: SEE ABOVE

6. **HEPATITIS B IMMUNITY TITER**
   Date: _____ **Result**_____ **Interpretation** ____**Positive** ___ **Negative**

MUST HAVE SIGNATURE OR STAMP OF HEALTH CARE PROVIDER OR COLLEGE HEALTH SERVICE REPRESENTATIVE

Name_____**Date Completed**_____

Address_____

Telephone_____