Phlebotomy

IOWA WESTERN

This form **MUST** be returned to: Iowa Western
Continuing Health Education
Looft Hall, Room 121
2700 College Road
Council Bluffs IA 51503

TO BE COMPLETED BY THE STUDENT (Please print clearly)

Name: _____
Last First Middle

Address: _____
Street/P.O. Box

_____
City State Zip

Phone: _____ Email _____

Fall/Spring/Summer 20____

Citizen: ❒ US ❒ Other (Specify)_____

Student ID (SS#)

Date of Birth

Month Day Year

REQUIRED IMMUNIZATIONS **Must be completed and signed by your healthcare provider**

MMR (Measles, Mumps, Rubella) (two doses required for students born in 1957 or later)

❒ a. Dose 1 given at age 12-15 months or later ..... #1 ___/___/_____
M D Y

Dose 2 given at age 4-6 or later, and at least one month after the first dose..... #2 ___/___/_____
M D Y
OR

❒ b. Laboratory/serologic evidence of immunity (*attach copy of lab report*)..... ___/___/_____
M D Y

Tuberculosis Screening

❒ a. **Tuberculin Skin Test:**

Date #1 given ___/___/_____Results_____ Date #1 read ___/____/_____Results_____

Date #2 given____/___/_____Results_____ Date #2 read____/____/____Results_____

❒ b. **Chest x-ray** (required if tuberculin skin test is positive) result: Normal _____ Abnormal _____

Date of chest x-ray ___/____/_____ *Attach copy of chest x-ray report*

Hepatitis B—Required for all students. (Three doses of vaccine or a positive Hepatitis B surface antibody)

❒ 3 dose Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❒ 3 dose combined Hepatitis A and Hepatitis B series

Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ **OR**

❒ Laboratory/serologic evidence of immunity or prior infection (*attach copy of lab report*) ___/___/_____
M D Y

REQUIRED IMMUNIZATIONS **Must be completed and signed by your healthcare provider**

Varicella (Either a history of chicken pox, a positive Varicella antibody, or two doses of vaccine given at least one month apart if immunized after age 13 years)

- ❒ History of Disease verified by undersigned clinician..... Disease date ___/____/_____ **OR**
- ❒ Laboratory/serologic evidence of immunity (attach copy lab report) ___/___/_____ M D Y
- ❒ 1 dose given at 12 months of age or later but before the student's 13th birthday. Date of shot ___/____/_____ **OR**
- ❒ 2 doses. Dose 1 given after student's 13th birthday. 2nd dose at least one month after first dose

  Date #1 ___/____/_____ Date #2 ___/____/_____

Tetanus-Diphtheria-Pertussis (Primary series with DTaP, DTP, DT, or Td, and booster with Td or Tdap in the last ten years). **If students have not had Tdap as an adult, they are required to get one dose**.

- ❒ Primary series of four doses with DTap, DTP, DT or Td

  Date #1 ___/____/_____ #2 ___/____/_____ #3 ___/____/_____ #4 ___/____/_____

- ❒ Booster: Tdap (preferred) ..... Date ___/____/_____

Covid Vaccination: Please Provide Copy of your Vaccination Card-**mandated for clinical**

Brand Given Date____/____/____ Date____/____/____ Booster____/____/____

Influenza Vaccination Date____/____/____

Healthcare Provider (Signature or stamp required)

Name (Print)_____ Signature_____

Address _____

City _____ State _____ Zip _____

Phone _____ Date _____